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# JOURNAL of The Connecticut State Medical Society

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THE CONNECTICUT STATE MEDICAL SOCIETY

Editor-in-Chief - STANLEY B. WELD, M.D.,  
54 Church Street, Hartford, Connecticut

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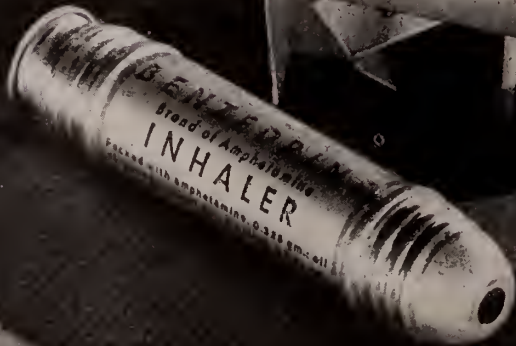
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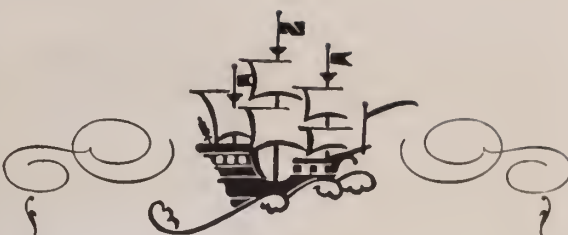
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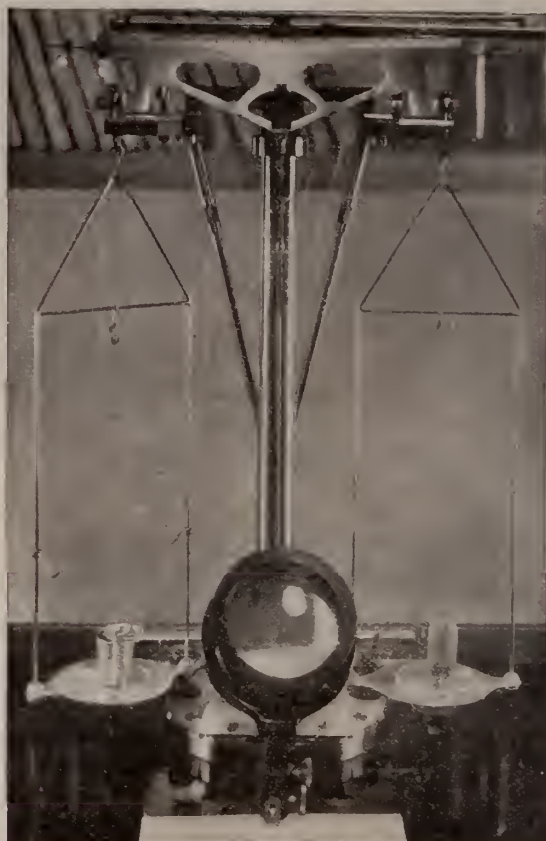
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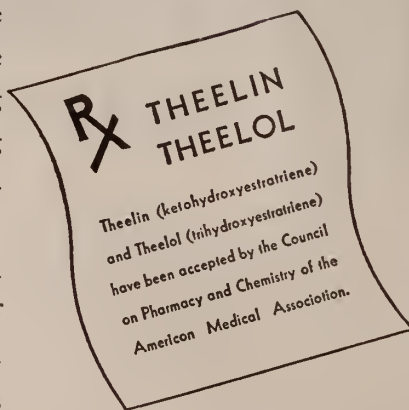
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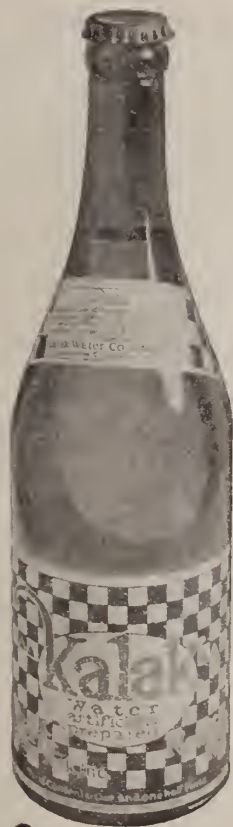
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—IRVING, NEW YORK STATE JOURNAL OF MEDICINE,  
JAN. 15, 1938.

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—HINSHAW, JOURNAL-LANCET, AUGUST 1937.

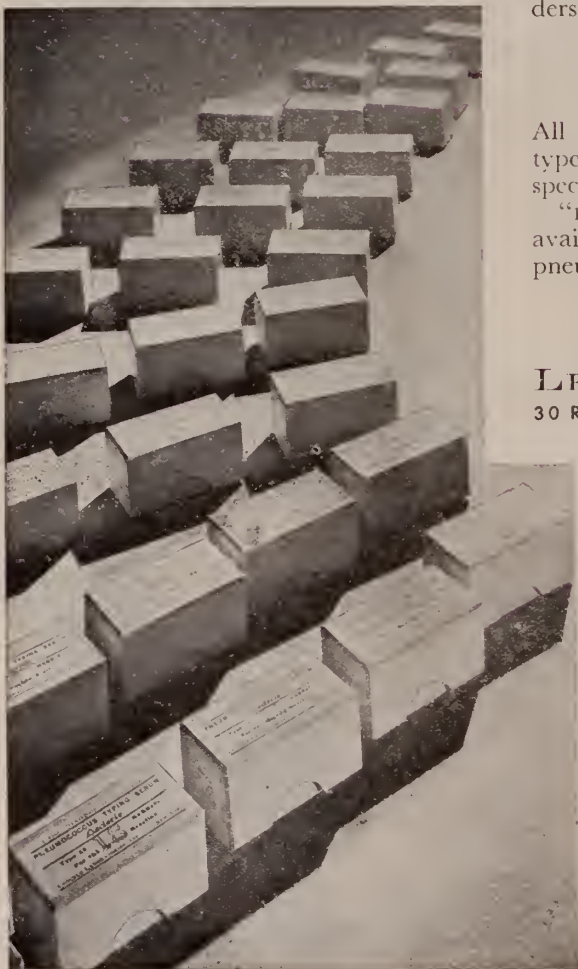
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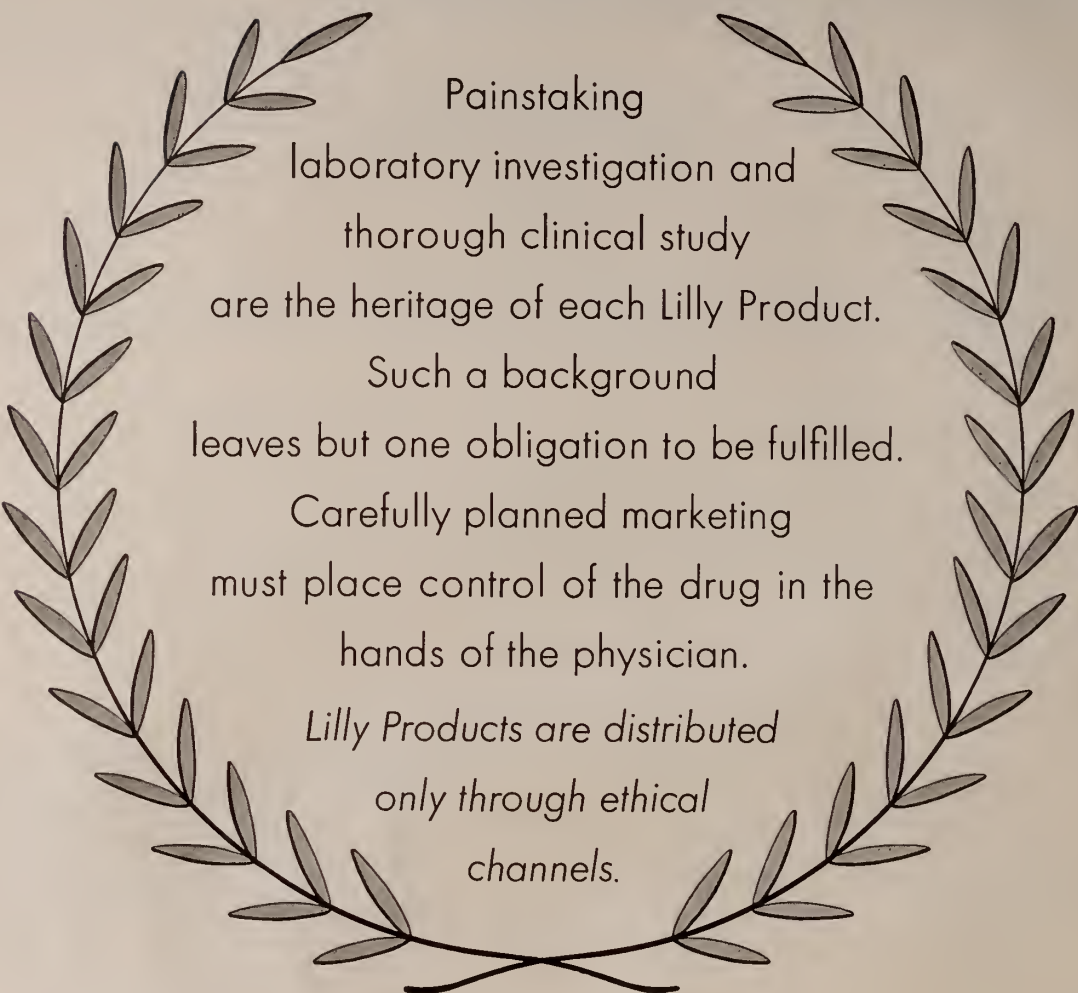


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1939

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# JOURNAL *of* The Connecticut State Medical Society

VOL. III.

JANUARY, 1939

No. 1

## Carcinogenic Substances\*†

ABRAHAM WHITE, Ph.D.

New Haven, Conn.

At the present time, it is generally accepted that there are at least three important factors concerned in the etiology of cancer. These are: (1) an heredity factor, (2) a virus factor and (3) a factor which may be termed an external irritant. The importance of heredity as a causative agent of cancer is seen in characteristic growths involving specific tissues. With regard to the virus factor, it is now definitely established that high molecular weight proteins are capable of stimulating proliferation or growth of tissue, at least in certain organisms. Insofar as external irritants are concerned, it seems possible to classify these into three important types: (1) mechanical, (2) hormonal and (3) chemical. The role of mechanical irritation in the etiology of cancer is seen, for example, in the lip cancer of pipe smokers and in carcinoma of the lung in connection with dust inhalation. For the present discussion, our interest is particularly in the hormonal and chemical irritants which have certain relationships to one another.

The skin cancer developing in many workers in the coal tar industry, particularly in England, was, in 1915, first definitely correlated with the nature of the products handled by these workers. In that year, it was demonstrated experimentally that it is possible to produce skin cancer in rabbits by repeated application of crude coal tar to a shaven area of the skin of the animals. This finding was confirmed in a number of laboratories and investigations were initiated to

determine whether the coal tar action was due to mechanical irritation or whether a particular constituent of the tar was responsible for the physiological result. In a series of brilliant studies, Kennaway, Cook and their collaborators in England succeeded in isolating in pure form from coal tar a chemical compound which exhibited the same type of carcinogenic activity as the crude coal tar, except that the pure compound was more effective in producing skin cancer. The active compound was shown, chemically, to be a derivative of phenanthrene.

The demonstration that a single chemical compound exhibited carcinogenic activity led to the search for other substances, either naturally occurring or prepared in the laboratory, which might possess similar physiological action and thus become valuable tools in the experimental study of cancer. A number of such compounds were prepared, with varying degrees of carcinogenic activity. Of outstanding interest is the fact that the most potent of these carcinogenic agents possess, in common, the chemical grouping known as the phenanthrene nucleus. Furthermore, this nucleus or grouping is widely distributed in nature in a variety of physiologically important compounds. Cholesterol, vitamin D, the bile acids, the sex hormones, the hormones of the adrenal cortex and some of the substances of the digitalis group represent compounds containing the phenanthrene group.

In some instances there is not only a chemical

\*From the Laboratory of Physiological Chemistry, Yale University School of Medicine, New Haven.

†Read at the 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.



similarity but one can also find resemblances in physiological action and suggestive significance to the problem of cancer. For example, it has been demonstrated that the injection of large doses of vitamin D into spayed rats will produce an estrous reaction in the animals, thus simulating the action of the female sex hormone. Moreover, investigators in the Department of Anatomy at the Yale University School of Medicine have produced mammary tumors in mice by the injection of massive doses of female sex hormone. This finding may be correlated with reports that extracts of human mammary tumors may exhibit female sex hormone activity. The relationship of the sex hormone to cancer is further seen in cases of adrenal virulism resulting from adrenal tumors. In this condition, it appears that the adrenal growth is manufacturing

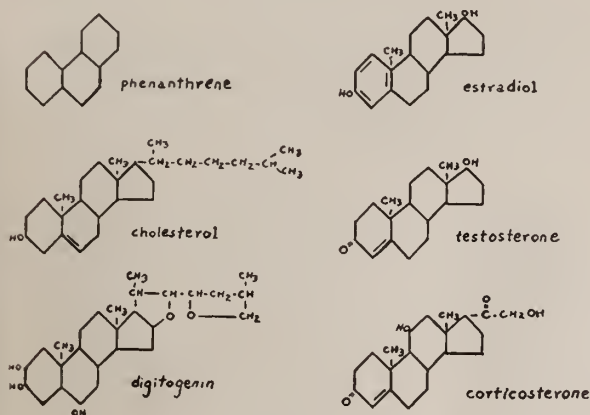


Figure 1

Chemical relationships among a few naturally occurring substances containing a phenanthrene grouping.

sex hormone. This suggestion is supported by a very recent report of the isolation of progesterone, the hormone of the corpus luteum, from adrenal tissue.

The close chemical relationship of the sex hormones and the adrenal cortex hormones to certain carcinogenic agents seems evident. The accumulating clinical and experimental data suggest that this relationship is not entirely a fortuitous one. Chemical and hormonal agents containing the phenanthrene group appear, indeed, to be extremely significant factors in the etiology of cancer, probably behaving as carcinogenic substances.

## GENERAL REFERENCES

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Fieser, L. F. The Chemistry of Natural Products Related to Phenanthrene. 2nd edit. New York. Reinhold Publishing Corp. 1937, 456 pp.



## SOCIALIZED MEDICINE IN SWEDEN

Dr. Palmer Findley of Omaha, (Nebraska State Med. Jour., Nov. 1938), calls attention to the prosperity of Sweden where there are today but 15,000 on relief in a country a little more than twice the size of the State of Nebraska. However, as Dr. Findley points out, Sweden is "draining her reserves for the purpose of bringing about the more abundant life for all her people." Apparently both the doctors and the public are satisfied with socialized medicine as it exists in that country. Very few physicians and only those of outstanding reputations practice independently. The department chiefs in a hospital receive a salary of \$3,000 to \$3,750 and in addition may realize an equivalent sum in private practice. The assistants receive about one-half this salary and may practice outside in addition. All other members of the hospital staff are paid \$125 a year and their keep and are not permitted to engage in private practice. The fees charged by the doctors are regulated and are very moderate. House calls range from \$2.00 to \$2.50, plus ten cents a mile. At sixty-five years the doctor must retire on a pension. Skilled labor is better paid than the doctors in Sweden, the average income being \$3,000 to \$4,000.

Every citizen between 16 and 66 years of age must carry health and old-age insurance, half the cost of which is borne by the employee. Private nurses are paid \$1.50 for ten or more hours. Midwives deliver 80% of all babies in Sweden. They are on a salary of less than \$400 per year plus living quarters and professional equipment. Medical education in Sweden is a long and expensive process, doctors being ready for practice somewhere between the ages of 35 and 40. All this necessitates high taxes and high living costs.



## Symposium on Behavior Problems in Children\*

EUGEN KAHN, M.D., Chairman

New Haven, Conn.

It is a great privilege for me to conduct, if I may say so, this Symposium, especially so as we are happy to have with us two pioneers in the field: Dr. Samuel T. Orton who comes as our honored guest, and Dr. Arnold L. Gesell who is our very own.

Starting this Symposium I am reminded of a remark my old teacher in Pediatrics used to make about the pediatricians. "We are always believed," he said, "to have an easy job because our patients are so small, but believe me our small patients give us plenty to do".

For more than two decades now the interest of a great number of physicians, in the first instance, pediatricians and psychiatrists, has been centered on the child. Much observation and much knowledge have been accumulated during this time, and more and more the idea is breaking through that in the long run we will have to do something in preventive medicine which, of course, will have to deal with the infant and the child everywhere and at all times. That is, our profession is increasingly interested not only in the sick, but also in the normal child. We are not going to argue about the question whether the behavior problems as they are going to be discussed here are normal or abnormal manifestations in children. Suffice it to say, that there are manifestations of all kinds during childhood and even during later periods of human life. There are manifestations that have biological, as well as psychological and social facets, as indeed every manifestation of every human being has even if we do not always take the time to go into all details concerning these various facets. In other words, the child is a human being, is a person, constantly going through an immense variety of situations to which he tries to adjust as well, or as badly, as his makeup and the situation in its widest understanding, make it possible for him. It is obvious that, since the

child is a young person, his future is longer and possibly even more important than the future of his elders. Maybe justice is not always done to this fact which, of course, has a very different appeal to different age groups. Dealing with the child in some way or other always means to help him to build up his life, that is the future.

Needless to say this point of view has been brought home most forcefully for many years by Dr. Gesell when he searched and wrote and taught about child development.

### THE EARLY DIAGNOSIS OF BEHAVIOR DEFECTS AND DEVIATIONS

Arnold L. Gesell, M.D.

New Haven, Conn.

#### The Problem

The medical control of behaviour defects and deviations in children begins with diagnosis. Who is the first to be consulted in regard to such defects and deviations? Not the psychiatrist, nor the neurologist. But, in the vast majority of instances, the general practitioner and the pediatrician, who really is, as Osler said, a specialist in general practice.

These behaviour problems do not always present themselves as clear cut diseases or well defined clinical entities. In the end they reduce themselves to problems of development. They are best understood and best managed when approached from the standpoint of development. The protection and the guidance of development have become part of the task of modern medicine.

The dimensions of the task are enormous as reflected by statistics for the country as a whole. The following figures relate to children of school age. *Many of these children were seriously neglected from the standpoint of developmental supervision during their preschool years.* A corresponding number are now of preschool age, dependent

\*Presented before the 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.



chiefly upon medical and public health agencies for protection.

In round numbers there are 300,000 crippled children, one-third of whom need special education. Some 10,000 are enrolled in public schools, state hospitals, and private schools.

There are 1,000,000 school children between the ages of five and eighteen years so defective in speech that they require remedial treatment and training (60,000 of these are now receiving corrective treatment). There are 3,000,000 children with impaired hearing, of whom some 18,000 are enrolled in schools and classes for the deaf. There are 50,000 with partial vision, who should be in sight-saving classes (5,000 of these are enrolled in such classes). and 14,400 blind children under twenty years of age, of whom 6,000 are being educated in state, private, or public day schools and classes.

There are 6,000,000 children of school age classified as malnourished (40,000 of these are in open-air schools and classes); 382,000 are considered tuberculous and 850,000 are classified as suspicious cases. There are 1,000,000 with weak or damaged hearts (375,000 of these with serious organic heart disease).

Three per cent of the elementary school enrollment, or about 675,000 children, present behaviour problems (10,000 of these children are in parental schools and special classes). There are 450,000 pupils in elementary grades mentally retarded to such a degree that they require special educational provisions. Sixty thousand of these are enrolled in special classes.

Many of the foregoing handicaps date from birth or early infancy. About one-third of the juvenile crippled and blind, about three-fourths of the deaf and speech defective, and practically all of the mentally subnormal come by their handicaps during the preschool years.

These figures in the aggregate reveal the strategic opportunities of preventive and developmental pediatrics. A large proportion of the defects enumerated can be prevented or ameliorated. Those which cannot be remedied are equally in need of consecutive medical supervision and guidance. A handicapped child must be early understood with respect to his limitations as well as to his positive potentialities. Often the adjustment of the parents to the handicap becomes the most serious aspect of the problem for the physician.

In all these situations *the pediatrician is very likely to play a critical role, for he, or the general practitioner, is the first to be consulted. He has the opportunity to make the early diagnosis, to bring about the most timely prevention and to furnish responsible guidance.* He may call in the assistance of specialists, but it is impossible to see how he can escape the professional application of at least the elementary principles of mental hygiene in his supervision of children of preschool age.

### Indices of Mental Development

From a medical standpoint there is no justification for a sharp distinction between mental and physical welfare. From the monistic standpoint of objective science, the mind of the infant is a reaction system,— a complex but integrated system which expresses itself in characteristic forms of behavior, in patterns of posture, locomotion, perceptual adjustments, in prehension and manipulation, in gesture and vocalization, in social adaptations. In these patterns of behavior the mind makes itself manifest.

The orderliness of mental growth is well illustrated by the reactions of the normal infant to one or more small red blocks, one inch in dimension. We have used these blocks to explore and to define the progressions of development of the neuromotor system. As the child matures the patterns of cube behavior change in a lawful manner.

Note how these patterns change from age to age: At 4 weeks the infant does not perceive the cube! At 8 weeks he holds the cube for a short time if it is pressed into his palm. At 12 weeks he regards a cube placed near him on a table; and at 16 weeks he regards the cube prolongedly. At 20 weeks he may corral it with both hands; at 24 weeks he picks it up on sight; at 28 weeks he bangs it on the table top. At 32 weeks he prehends the cube with increasing thumb opposition; at 36, 40, and 44 weeks he brings two cubes into more and more elaborate combination. At 48 weeks he brings one cube above another in a sketchy manner which promises tower building at a later date; but the behavior pattern of adaptive release is not yet mature. Incipient tower building with rudimentary release of the block begins at 1 year. At 18 months he may build a tower of three or more cubes. At 3 years he can look at a model and make a bridge of three cubes. He takes two cubes and separates

them by less than an inch; then takes the third cube to bridge the gap. This bridge-building ability is a symptom of maturing intelligence.

Significantly enough we have found that the 18-month-old child cannot, even with instruction, build such a simple bridge of three blocks. He must double his age before he is equal to the test. He can build a tower at 18 months. Superficially it would seem to be more difficult to build a balanced tower of five cubes. This demands a nicer degree of motor coordination. But the laying of the bridge requires more judgment. The mechanism of behavior growth is so complicated that it takes 18 months of added neuromuscular elaboration before the more complicated pattern of bridge building comes into expression. Towers before bridges is a law of human growth.

Because the nervous system follows lawful sequences as it matures, certain patterns of behavior can be considered and used as indices of mental growth. Even patterns of cube behavior have significance in developmental diagnosis.

By a discriminating application of such indices and norms it is possible to differentiate between various forms and degrees of developmental defect. The norms assist also in the detection of neurological complications.

### Developmental Defects

Three major kinds of defect may be recognized: (1) Mental deficiency; (2) Birth injuries; (3) Specific disabilities.

(1) **Mental deficiency.** A diagnosis of mental deficiency should only be made when there is a permanent generalized reduction in the development of the nervous system. A clinical diagnosis of mental deficiency must always rest on evidence of actual or latent retardation.

(2) **Birth injuries.** It is especially important to avoid an unqualified diagnosis of mental deficiency (feble-mindedness) merely on the basis of motor retardation and motor disability such as may arise from selective damage to the brain either prenatally or during the process of birth. Such cerebral birth injuries assume innumerable clinical forms. These injuries, from the standpoint of time or occurrence, the extensiveness and severity of the lesion, and associated physical conditions, vary enormously and the consequences of these variations are in turn much influenced by the original growth potentialities of

the child. Accordingly, the resultant clinical picture may range from a minor restricted paralysis to profound generalized idiocy. In the intermediate zone between these extremes there are many partial approximations to normality combined with a wide array of more or less extensive defects. A child with relatively grave motor disability may retain many capacities of thought and feeling which make his essentially normal in his psychology. Even when the speech mechanisms are impaired and ordinary forms of social communication are reduced, it is wise to exercise great caution with regard to the diagnosis of mentality and prognosis of educational possibilities. In many of these cases of birth injury we are dealing with children who were potentially normal or even superior and who retain a residuum of relatively unimpaired equipment and developmental latency. It is unwise to characterize or to treat the condition as one of ordinary mental deficiency. Careful guidance and instruction of the parents are particularly important in these instances.

(3) **Specific reading disabilities.** A word in regard to the early diagnosis of specific reading disabilities. Here again we are dealing essentially with a developmental deviation. Reading disability may or may not be caused by a birth injury. It represents a defect in the inherent reaction patterns or an imperfect correlation of associated patterns. Developmental diagnosis may reveal potential reading disability as early as the age of two to four years, as shown by Burton M. Castner, in studies of the mental development of preschool children, referred to the Yale Clinic of Child Development.

There are at least a half dozen premonitory indications: (1) Scattering and inconsistency in the developmental examinations; (2) Specific weakness in drawing tests; (3) Specific weakness in number concept; (4) Left-handed or atypical directional tendencies in drawing, including tendencies to reversion; (5) Irregularity in speech development; (6) Atypical personality development.

When a number of these signs consistently reappear in a series of examinations, precautionary guidance measures may be taken to forestall or ameliorate the important behavior disorders and reading difficulties to which Dr. Orton has called attention.

In summary, I would emphasize again that



the great majority of developmental defects and deviations can be diagnosed in the preschool years. Although the tendency of growth is toward an optimum we are not justified in the common medical assumption that young children will outgrow their difficulties simply because they are so young. Many mental defects are not outgrown and to assure a parent that they will be outgrown is a form of false diagnosis which often leads to unfortunate mental hygiene results both for the child and his family. Even though certain defects are irremediable there is a vast field for constructive medical service, particularly if the problem is approached from a developmental angle rather than a disease angle.

*The child is the patient, but the problem is peculiarly a family problem which may involve brothers and sisters, and almost always involves the mental hygiene of the father and mother.* In a great many cases the consequences of a severe or troublesome case of mental deficiency go far beyond the child and may even affect the health and happiness of the marital situation.

#### Imparting the Diagnosis

For these reasons the physician should make a special effort to assist the parents in accomplishing a constructive adjustment to their problems. Assistance toward such a personal adjustment may be medically of more importance than the specific recommendations in behalf of the child himself. Actual injustice may be done if false hopes are too long nourished. In the long run the best service may be rendered through judicious frankness. The diagnosis should not be imparted in drastic, technical terms but should be formulated in tactful, descriptive terms which spare the sensibilities of the parent and yet lead to the truth. Blunt labels like moron, imbecile, and idiot should be avoided.

The full force of the diagnosis need not be imparted at once, but may be progressively approached in succeeding visits. For this very reason it is desirable to have follow-up contacts with the parents and not to dismiss the case too abruptly. Instead of classifying the child with a label it is better to state in effect that "the child is growing slowly, that he will gain some more, but more slowly than children of his age." Only in the most profound cases are the growth possibilities completely destroyed. After an interval in which the amount of improvement is

appraised, the parents can be brought still more closely to the truth of the situation. It is not necessary, however, to prescribe endocrine gland tablets as a blind and as a distraction or as the fictitious justification of a fictitious hope. Such therapy scarcely deserves the name of medical practice, and in the end proves a disservice.

Especially unfortunate are those cases, all too frequent, in which parents, abetted by undue professional encouragement, cling for years to the faith that something can and will be done to make their defective child normal. This misplaced faith deepens and becomes an unhygienic method of escape from the realities of the situation. Thus a second problem is added to the first and that without in any way solving the first.

It is the physician's duty to help the parents to face reality as early and as steadily as possible. To what extent and in what manner the diagnosis is to be imparted is a problem that must be left to the wisdom and tact of the physician. The circumstances of each situation vary so greatly that no general policy can be laid down. It serves no good purpose, however, to nourish false optimism which is doomed to disappointment. If such a policy is pursued too long and too blindly, new difficulties are created. The reality of the mental defect is difficulty enough. By wise and gradual methods, if not by immediate approach, the facts may be imparted. The mental welfare of the family is even more at stake than that of the child as an individual. For this reason every case of mental deficiency constitutes a challenge to the highest type of medical service in spite of the limitations of curative treatment.

#### THE PRACTITIONER'S ROLE IN ADVISING ABOUT DEVELOPMENTAL PROBLEMS OF THE PRESCHOOL CHILD

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The practitioner is more and more taking on a new role in his advising about the care of the preschool child. The sick child no longer absorbs so much of his time and with the periodic examinations of the preschool child he may not only advise the mother about the development of her child but he also has the opportunity to add to his own store of knowledge in watching

the child's development and thus to compare child with child. He is not only becoming aware of developmental sequences but also of problems which arise as deviates of the usual sequence. However, the problem is frequently of the adult's making because the developmental sequence has not been fully understood and therefore a conflict with parent and child may arise. The child naturally and in so far as he can, makes every effort to be true to the laws of his being. Therefore, more listening than dictating would set the adult on the right track where the child is and from that point of vantage the adult may more easily and surely steer the developing child.

The practitioner's role is to interpret the developing child for the parent. So often the mother is so close upon the child that it may be difficult for her to view the child in perspective. But at the same time it is the mother with her multitude of questions arising from the practical everyday problems that she is encountering, who is stimulating the practitioner to find the answers to her questions. And it is then for the practitioner to decide whether the mother's problem is one within a normal sequence of development, or whether it is from a superimposed conflict between mother and child because she did not understand the normal sequence of development or was disturbing this sequence in some way. The practitioner can also point out trends of development, thus relating the child's present development to his past development and even to conjecture his future development. Thus the parent is often given a dynamic evaluation of her child which may be the means of more easily interpreting future development.

Development itself is one of the biggest problems the child has to face, without adding any unnecessary complications. Each child meets development in his own way, but to understand each individual more fully, the knowledge of the supposed norm is a handy yard stick. For example, the sequences of motor development have been known for some time. A few of these items are as follows: The 1-3 month old infant in supine has a tendency to hold his head to one side (the tonic neck reflex) and assumes a mid-line position at 4 months. He sits supported at 4-5 months, sits alone at 7-8 months, goes from sitting to creeping at 9 months, creeps alone at 9-10 months, pulls himself to standing at 10-

11 months, takes a few steps at one year or walks with his hands held and walks alone by 15 months or somewhat before. Most of these stages are not interfered with and are responded to as they appear. However, there are sufficient deviations to produce conflict in handling if not fully understood. Some infants from 1-3 months have a marked preference to hold their heads on one side and cry if placed on the other side. If the mothers knew how short this stage lasted they wouldn't be so diligent about shifting the child from one side to the other. There seems to be a general fear about allowing the child to sit up too soon even though one can readily see the true delight the 3 months old child expresses in sitting up. Even earlier than 3 months the colicky baby often shows marked relief from his symptoms if he is kept in a half sitting position. There has been a fetish for keeping babies on their stomachs even from birth. They say it strengthens the back muscles. Some babies will sleep no other way from birth, yet others resist it with intense crying even up to 9 months. The ones who demand to be on their stomachs are usually the early creepers; the ones who resist it, the later creepers. A baby may sit very well at 7 months and still be unable to go to prone at 12 months to secure a toy out of reach. The only way he can secure it is to cry for it. A general opinion may be that things shouldn't be too easy for him and that he would be able to get it if he kept on trying. But he only cries and doesn't try. In these cases there are usually curious gaps in the child's development as though he had not experienced the transition from one stage to the next. This undoubtedly makes him more dependent upon the adult. As a specific example, here is a child who sits well at 7 months. He did not creep until he was walking well at 18 months. He adored to walk with his hands held at 9-10 months when he was put in a tailor-tot. He pulled himself to standing at 12 months and though he walked well in his tailor-tot he showed no inclination to walk alone at 13 months. It was at that time the tailor-tot was taken away from him for fear it was interfering with his walking. A large part of his days from 13-14½ months were spent in crying in his play pen. Finally his mother broke down, returned his tailor-tot to him and he walked alone 1 month later at 15½ months. Even at 17-18 months he could not get up in the



middle of the floor even though he walked well. It was not until he crept after 18 months that he could get up alone. If he fell, it again was impossible for him to get up and he cried until his mother picked him up. It was not until he was three years of age that he responded to her telling him that he could get up by himself. But she had to be there beside him. She, however, picked him up with words rather than with her hands. A few months later he would respond to her voice even though he didn't see her and now at 3½ years he tells her about his falls some time after they have happened. These deviations are not only present in his motor development, but also in the other fields of his development. The startling thing is that he is so very consistent in his behavior, which is clearly evident when patterns have once been analyzed.

Another field of development which is perhaps not as fully known or understood as the motor development is that of elimination. Mothers so often have the idea that it's up to them to establish the habit of responding to the toilet at certain times, and the earlier they begin the easier the habit will be formed. Too many mothers have failed in their efforts or have spent too large a proportion of their days putting or keeping the child on the toilet to warrant the continuance of this practice. The first child is usually the one who suffers the brunt of this training regime whereas the second child often enjoys carefree handling until the time that he himself makes some response to the process.

The stages of the development, for example, of bladder control are very definite and may be interpreted to some extent by physiological changes in the organ itself. The neonate may fuss or cry when he is wet, but this does not usually concern him again until he is around one year of age. Then he often knows when he is urinating and pulls at his pants when they are wet, but he does not realize that the puddle on the floor is something he has done until he is 15 months of age. Then he may point to the puddle with pride saying "see" or he may splash his hands in the puddle. The mother is apt to slap his hands or punish him in some way feeling that he knows better. She should, however, realize that this is a stage of development and that in everything the child learns backwards. He doesn't know that he is going to urinate before

he knows that he has urinated. This is after all true learning by experience. With punishment the child may stop telling where the puddles are and when the mother realizes she would really like to know where the puddles are and stops the punishment, the child again points them out.

There are, however, times when the child responds well to the toilet after one year of age though he doesn't ask for the toilet. It is his dryness which asks for the toilet, either after his nap or an afternoon walk. At these times he responds readily but that does not mean that he will respond equally well at other times. At 15 months even at these more favorable times he resists the toilet and goes immediately after he has been taken off of the toilet. This is most probably a sphincter contraction response which normally precedes a sphincter release. A mother may use this to her advantage by putting the child on the toilet and allowing him then to urinate on the bathroom floor where it can be quickly and easily mopped up. This period does not usually last more than 2-4 weeks.

From 15-18 months the child often shows great interest in mopping up his puddles and a cloth should be provided for him to secure when he needs it. During this same period he is responding more frequently to the toilet and may occasionally ask during or before he is going to urinate.

From 18-21 months he may have lost interest in mopping up his puddles which are occurring less frequently and therefore are drawing more attention. Often he is asked "Who did that" and he blithely blames it on grandmother or the kitty. This becomes a jolly game similar to the game of "no-no" at one year of age. But soon the jolly game is stopped and is used as evidence against the child at the age of 21 months, when the puddles markedly increase in number. Father often steps in at this point with a more strenuous form of punishment for he feels sure that if the child felt guilty enough to blame his puddles on grandmother, that he is capable of telling before he goes. Punishment does not help and often makes the situation only worse and often sets up a fear in the child at the father's home-coming. If the father had waited a few months he could have avoided this trouble. The cause of this frequency of urination may be associated with the attempt on the part of the bladder to contract down on small amounts of urine.

By two years of age the child is usually telling before he wishes to urinate. He has few daytime accidents. But then approaching three years of age he encounters a new phase of trying to put off going as long as he can. He dances up and down as he continues his play and having finally just begun to wet his pants he rushes off to ask for help or to go by himself. He does not make puddles at this age, nor does he urinate frequently. This may be interpreted as the stage in which the bladder is attempting to dilate as much as it can. This stage just precedes the more easily routinized times for going to the toilet.

Of course there are many deviations from this sequence of development, but the core of it is always present. The child who is slow in talking and does not respond much to persons may be late in bladder control and may not finally express his needs by going to the adult, but by going directly to the bathroom even though he is unable to care for himself. Many such deviations must be interpreted for the adult in view of the qualitative evaluation of the child. But it is from this central point of developmental sequences that one can branch out into the study of deviations and relate them not only to the specific part of the child's behavior under question, but also to his total personality.

### BEHAVIOR DISORDERS ASSOCIATED WITH THE DEVELOPMENTAL DISORDERS IN LANGUAGE ACQUISITION

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In my opinion it is an error to attempt to evaluate emotional factors after any obstacle such, for example, as a strephosymbolia has been existent for a long period. It is essential to study such cases early — soon after their first appearance — to correctly evaluate the relative part played by the organic and functional elements.

It seems equally erroneous to attempt to classify such cases as exclusively organic or exclusively psychogenic. This is always misleading — these two factors operate hand in hand and any attempt to say that either is the sole cause results in narrowing the vision of the examiner and frequently in faulty remedial technique through failure to treat both factors.

Disorders in development of certain functions

which in the normal adult are characterized by unilateral cerebral control have been under intensive study for the past 12 years and may be classified as follows: 1. Defective development in understanding the spoken word — *developmental word deafness*. 2. Defective and delayed development of speech but without word deafness — (a) *motor speech delay*, (b) *persistent speech infantilisms* and (c) *stuttering and stammering*. 3. Defect or delay in learning to comprehend written or printed language — (a) *Strephosymbolia* or *specific reading disability* and its congener, (b) *specific spelling disability*. 4. Defective development of the ability to write — *special writing disability* and 5. Defective or delayed acquisition of skill in trained movements — *developmental apraxia* which may be either of the (a) motor or (b) ideational type.

Because of the marked difference in frequency of occurrence of these syndromes our observations of the behavior disorders which are associated with them vary considerably. By far the largest numerical group which we have seen and thoroughly studied is the strephosymbolic. Of these our records now include approximately a thousand cases of all ages and of all degrees of severity. This group has, therefore, been chosen to form the backbone of this discussion and additional remarks concerning specific cases of the other syndromes will then be added.

The most common deviation in behaviour in children who have met an obstacle in learning to read is a feeling of inferiority or inadequacy. This is frequently masked by the child or may be offset to some degree by various compensating superiorities. Often its presence is most clearly demonstrated by the relief which the child exhibits when remedial measures are beginning to be productive and the child sees he can learn to read if taught by the proper methods for his particular needs. That this is secondary to the obstacle is rather clearly seen in many cases by its complete absence from the child's general reaction pattern up to the time of encountering the failure in learning to read. Not infrequently this feeling of incompetence overflows the field of reading and affects all scholastic endeavors and occasionally even activities in other fields.

"Emotional blocking" or the panic reaction which results in completely silencing the child when school topics are brought up is a not infrequent result of a severe reading disability.



Again this may be limited to school topics or may spread so that the whole expressive mechanism is more or less inhibited.

A distinct feeling of frustration is a not uncommon picture with those children who have serious strephosymbolic confusions. This is as a rule definitely limited to the field of the obstacle — reading and spelling, with writing as a frequent complication — and does not extend to arithmetic or to other activities. This frustration may readily reach the stage of complete disgust and lead to throwing of the book or other overt expressions.

In earlier reports the writer mentioned a paranoid reaction on the part of the strephosymbolic child as occasionally met. In the much larger series here reviewed these have proven to be relatively rare and practically always can be traced to remarks by parents or others blaming the teacher or the school with the child's failure.

The behavior disorders above outlined are chiefly those affecting the child's own emotional development but these not infrequently lead to compensatory activities which are more positive in character and may fall in the category of overt anti-social acts. Thus, the child who is failing in competition with a younger brother in the scholastic field may develop a bullying attitude to express his physical superiority and even beat up the brother rather severely. Any type of mischief may serve as the means by which a boy who is failing in school may attempt to express his abilities in other fields and thus to prove to himself and his friends that he is not so stupid as his work in the reading class would imply.

One of the common reaction patterns of the older boys whose failures have not been properly related to their defect in reading or in whom this has been recognized but inadequately treated is that of a distinct antagonism not only toward schooling as a whole but toward all those who do learn with comparative ease. Cases with this feeling deeply ingrained have been encountered not infrequently and form in the author's opinion a rather prolific source of individuals with an extreme anti-social attitude. Whether or not they ultimately throw in their lot with the agitators and social malcontents will depend on what degree of compensation they obtain from other activities. Those who are successful in a job after leaving school will probably adjust themselves fairly well but their prejudice against

education and the educated is definitely an unwholesome trait which could undoubtedly have been prevented by correct diagnosis and adequate treatment of the reason for the failure in school.

Explosive temper outbursts out of all proportion to the precipitating remarks and aimed at teacher or parents are occasionally to be traced to the high irritability threshold maintained by constant failure in school. This genesis of the outbursts is supported by their complete disappearance as soon as the failure in school has been explained to the child and a sympathetic correctional program instituted.

No general statements can be made from our material concerning the relation of developmental word deafness and behavior disorders. These cases are as yet few in number and since the effect on the child begins in infancy (in contrast to strephosymbolia which does not show itself until the age of six or eight) it is difficult to untangle the child's inherent reaction patterns from those engendered by the disorder. In one case we have observed outbursts of belligerent panic, leading to a physical attack on his school master, in a boy who understood little of what was said to him unless this was put into very simple words and with a slow delivery. Subsequent treatment of this boy led us to feel that his outburst was fundamentally a defensive panic. In another case a marked feeling of inferiority and a lasting depression had followed many years of school failure and both of these disappeared promptly under effective treatment. No grouping of the reaction patterns in this syndrome is possible as yet, however, because of the small number of cases intensively studied. There is, however, an increasingly large number of cases in our records in which a measure of defect in understanding spoken words is a complicating factor in cases of reading disability. These boys are apt to be actively seclusive — withdrawing from contacts with others and preferring to find their own entertainments in which neither speech nor reading is needed. Their behavior patterns are otherwise not unlike the strephosymbolics. Their importance lies in the recognition of the auditory element in their scholastic troubles. Ordinary remedial reading measures are not effective in these cases without added correctional methods to increase the understanding vocabulary for spoken words.

Motor speech delay.— The children who are slow in learning to talk but who have no defect in understanding speech do not show in our experience any very consistent behavior deviations. They are passively seclusive — not apt to seek out new contacts but receptive to them. Their behavior as a rule is that of a shy friendliness. We have not observed much of a feeling of inferiority in them nor are overt behavior infractions as a rule a part of this picture.

Stuttering forms an excellent example, in the writer's opinion, of the fallacy of attempting to evaluate causative factors when the condition is of long standing and there has, therefore, been time for the fixation of many secondary reaction patterns. I believe that these cases must be seen early, i.e., shortly after the onset at two to three years of age in one group or at six to eight years of age in the other major group to properly assess the organic and emotional moments. When seen early, soon after their handicap has made its appearance, we do not consistently find any of the emotional deviations so universally quoted as causative by those whose studies are based on adults. At this early stage of their trouble there is no undue feeling of inferiority, no fear of speaking, no unusual timidity, no seclusiveness, no avoidance of social situations demanding speech and certainly no constant lack of persistence or of self-confidence. With that group of children who begin to stutter during the first critical period of speech development, i.e., when speech and new motor patterns are first actively developing, it is often difficult to obtain a clear picture of the personality as it was before the stuttering began. With the other large group, however, those whose speech defect first becomes manifest at the second critical period, i.e., from the ages of six to eight, when written language is being added to the spoken form, which has already been well acquired, it is frequently possible to get from the history a clear-cut picture of the child as he was before the stuttering began and here we fail to find with any regularity the factors listed above. As a rule stuttering and stammering exert their chief effects on the patient himself and do not give rise to overt behavior disorders of an anti-social type, although an occasional stutterer with an inherent belligerent trend will find himself in many fights with those of his companions who mimic him or make fun of his disability, and

in one of our cases this was misinterpreted by the school authorities as a pernicious truculence.

The special disabilities in learning to spell and to write are apparently not especially productive of behavior disorders. Poor spelling is often looked upon as something of a joke and poor handwriting can often be largely hidden except from the teacher. One group of poor spellers occasionally becomes troublesome, however. When the teacher does not understand that bad spelling may have a real organic origin, blames the errors onto carelessness and punishes the child on that basis, the victim is apt to develop a resentment toward that teacher which may color his reaction toward all school work and may lead him into retaliatory mischief.

The study of those children who are extremely slow or unskillful in learning new motor habits — the developmental apraxias — is still in its infancy. This forms the forefront of our current research aims. We are attempting the analysis of extremely clumsy movements in a selected group of such children by means of slow moving pictures and using the same pictures to demonstrate to the child himself where his movements can be improved. The number of cases studied here as yet is too small to draw any conclusions as to behavior patterns but we do anticipate that improvement or correction of poor motor habits will have a marked influence on the morale of the patient. Most small boys would much rather succeed on the baseball diamond than in the classroom and any measure of general self-confidence gained by increasing motor skills may logically be expected to improve the boy's efforts in other lines as well. So far we have not been able to associate any particular type of behavior disorder with developmental apraxia although in general, of course, the boy who is unsuccessful in his athletic competition is fertile soil for mischief making of all sorts.

#### PROBLEMS OF OLDER CHILDREN AS SEEN IN GENERAL PRACTICE

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The problems of older children include all varieties of personality and behavior disorders. The difficulties may be exhibited in the educational field as the result of emotional disturbance, as secondary to language disorders, or from



many other causes. Maladjustment in the sphere of social and vocational adaptation may also be encountered. Any or all of these childhood problems may come to the attention of the general practitioner. If children with difficulties in these areas are brought to the physician for advice, it is usually because of the place that the general practitioner occupies as a counselor in the affairs of the family. Such children are not usually sent to him because he is a physician. If he is asked for advice about such problems by the parents, it is rather because of his previous contact with the child or his family. There are, however, a group of disorders in older children, the nature of which makes the parent, or other responsible person, immediately think of the doctor as the proper source for advice. The character of these problems is such that the complaints which are made to the physician are likely to be referred to some specific organ system of the body, or else to be of such a general non-specific type that they are given the all inclusive term of nervousness, or nervous breakdown.

Of these complaints referable to the various organ systems, by far the majority are referred to the gastro-intestinal and genito-urinary systems. Less frequently the motor system is involved and still less frequently the cardiovascular system. As compared with adults, cardiovascular complaints of a neurotic character are strikingly infrequent in children, though the physician in examining emotionally upset children will often encounter an emotional tachycardia.

Emotional conditions with complaints referable to the gastro-intestinal system are extremely common in children. Disorders of appetite, ingestion and digestion have been estimated to run as high as twenty-five per cent of all pediatric cases. While such disorders are very frequent among young children, they are also of common occurrence among older children. Experience would seem to indicate, however, that the emotional character of the complaints is more likely to be recognized in the younger group than in the older.

Anorexia is probably one of the most common symptoms noted by the physician. It is seen in children and adults alike, and accompanies a great many illnesses of an organic nature. The very regularity with which anorexia is seen as

one of the symptoms of physical illness tends to make its recognition as the presenting complaint of an emotional problem difficult. Even when a careful physical examination has failed to reveal any organic basis for the lack of appetite, the physician is more apt to prescribe a tonic than to make a search for the emotional factors which may be at the source of the difficulty. Yet, every one is familiar with the phenomenon of loss of appetite under emotional stress. It is only when the cause of the emotional stress is not obvious or dramatic that it is overlooked as the basis of the anorexia.

Constipation is another complaint or symptom which is common for individuals of all ages. Because it is common in older children, it must be included in those problems of this group which are brought to the physician. After all known and ascertainable organic causes of constipation have been eliminated, there is left a considerable number of cases where the etiology of this symptom must be sought in the emotional life of the child. Like the symptom of anorexia, constipation is so frequently associated with structural conditions of the gastrointestinal system that the possibility of emotional factors is often overlooked. Even when the difficulty is labelled as "functional", this often only serves to relieve the physician of anxiety regarding some possible obstruction. A purgative, laxative or enema is ordered.

Diarrhea, like anorexia and constipation, is also frequently associated with organic etiology. If structural changes are not ascertainable, or some acute infectious process discovered, we are likely to ascribe the condition to some indiscretion of diet. If we remember, however, how commonly diarrhea is associated with fear or anxiety, then the presentation of this symptom without apparent organic basis should act as a warning signal to investigate the emotional status of the child.

There are, of course, many other complaints relating to gastro-intestinal function which are brought to the physician for diagnosis and treatment. Digestive disturbances with nausea and vomiting are not uncommonly the result of emotional distress. Refusal to eat, or fear of eating, are apt to be recognized as emotionally conditioned. Difficulty in swallowing, however, is more apt to result in a search for obstruction in the pharynx and esophagus, than in obtaining

the anamnesis which would bring out its possible hysterical character. Soiling, once an organic basis for it has been excluded, is readily recognized as a habit problem. It belongs in general to a group of infantile behavior manifestations which may have existed since infancy, or to which the older child may have returned as a result of emotional difficulties which are intolerable.

Next in point of frequency to complaints involving the gastro-intestinal system are those which are referred to the genito-urinary apparatus. Unlike the diversity of neurotic gastro-intestinal complaints, neurotic symptomatology referable to the genito-urinary system is limited largely to enuresis and menstrual disturbances.

Enuresis is not typically a problem of older children as it occurs anywhere between the age of three and puberty and not infrequently in adulthood. In younger children, the difficulty is usually thought of as a failure in the proper training of toilet habits. With the case of older children, the general practitioner is likely to look for inflammation or other affections of the urinary tract. Yet, careful examination of this organ system, as well as search for possible lesions of the nervous system, fails to account for the vast majority of enuretic children. It is not surprising that this should be so, for control of urination is a matter of social custom rather than one of organic necessity. It is well, then, to look into the conditions of the child's life under which such social prohibitions are presented and into the psychological and emotional factors which condition, or perhaps fail to condition, the establishment of automatic control over micturition. With these considerations in mind, some thought should be given to the rationality of operative procedures, predicated upon no demonstrable pathology, which, even though by chance should be followed by a cessation of the enuresis, may contribute further to the distortion of the emotional life of the child.

There are a number of complaints related to the muscular system for which children are commonly brought to the general practitioner. Hyperactivity or chronic restlessness is a frequent complaint. The parent is more likely to call it nervousness. It is a symptom of great annoyance to parents and teachers. There are

probably constitutional differences in the degree of muscular activity in different individuals, but much of the hyperactivity of children results from the tensions created by prohibitions against the normal use of muscular energy. Very often hyperactivity is an expression of the emotional tension of the child. This emotional tension may of course be due to an innumerable variety of causes. Sedation in such cases may relieve the annoyance of the parents but does little toward the solution of the child's real difficulties.

Involuntary movements of all types, tics, spasms, habit spasms are not infrequent complaints of older children. The movements appear to be purposeful, but the child does not know what the purpose is, or even that he has made a movement. If his attention is called to it, he may be able to control the movement for a short time. These are in the nature of compulsive acts.

Both over-activity and various types of involuntary movements are often confused with chorea, which is of course organic in its etiology. The confusion with over-activity may be distinctly injurious to the child, as the physician is likely to order further restriction of activity, if his diagnosis is one of chorea. He thus serves to aggravate the hyperkinesis, especially if it has been conditioned by excessive prohibitions against muscular activity by the parents. It is astonishing how many parents of these over-active children say that the doctor has said that the child is "on the verge of St. Vitus Dance," and that all precautions must be taken to reduce activity. The implication for the parents is that if they are not careful, the condition will progress to chorea.

Anxiety attacks are a very common occurrence among children. One might say that most children have at least a mild anxiety attack at some time. This should not detract from the importance of the more moderate or severe attacks. Children suffering from anxiety are likely to be brought to the physician because of the associated somatic symptoms, rather than the apprehension that the child shows. The feelings of discomfort and anxiety may vary greatly in their degree of severity in different children, or in the same children at different times. This is true also of the somatic symptoms such as tachycardia, dyspnea, tremor, sweating



and diarrhea. Sometimes there is dizziness and fainting. Insomnia is occasionally the chief source of complaint. Nightmares and night terrors are merely nocturnal anxiety attacks.

The general practitioner will not be troubled with differentiating the anxiety attack in children from angina pectoris, as he often is in the case of the adult patient. If gastro-intestinal symptoms are prominent, the condition may be mistaken for some organic dysfunction of the alimentary tract. Occasionally, when the somatic symptoms are mild and the anxiety predominates, the false conclusion may be reached that the child is malingering. This is more likely to occur when the physician arrives after most of the somatic symptoms have disappeared, and the parents are unable to give suitable description of what they often call a "spell".

These, then, are some of the more common problems of older children that are likely to be seen in general practice. The difficulties discussed are primarily psychoneurotic, but because of the somatic symptomatology, will be directed usually to the physician. The problem of differential diagnosis is an important one. As has been indicated, the frequency with which many of these symptoms form a part of the symptomatology of common organic illnesses tends toward an oversight of their commonness as psychoneurotic complaints. Even if their neurotic character is appreciated, the application of such terms as functional gastric disturbance or gastric neurosis is likely to focus the physician's attention exclusively on the organ system in question, rather than upon the fact that the psychoneurotic condition is a reaction of the organism as a whole. This point of view leads often to a symptomatic treatment rather than a careful inquiry into the life experience of the individual child. Such an inquiry might well lead to an understanding of the difficulty and a suitable therapy be indicated. Certainly, more lasting results might be expected from such an approach. With more consideration for these types of problems in children, one would expect to see a decrease in the number that seek non-medical help. Only the physician is capable of making the careful physical examination so necessary for differential diagnosis in these disorders and for inclusion of the physical status of the individual in his evaluation of a total organism reacting to its environment.

## EMOTIONAL REACTIONS AT LARGE AS A PEDIATRICIAN SEES THEM

Robert Salinger, M.D.

New Haven, Conn.

When it was first suggested that I speak about emotional reactions as encountered in pediatric practice I planned a conventional discussion of the subject. First was to come the question of approach to younger children, pointing out that the pediatrician who can examine his patients aged 6 to 30 months in such a way that his day is not a series of catch-as-catch-can battles has a big advantage over those using a different approach. Then I was going to say that as important as the diagnosis of flu, measles, appendicitis or other specific disease is the reassurance that the physician is able to give to mother and child. Also I was anxious to point out how large a part of our time was spent with illness, disciplinary problems, feeding and digestive disturbances which were wholly the result of a family situation.

In August I went to California, and was so struck by what I saw that I've been full of thoughts and reactions since, and in a simple and unmedical manner would like to tell of my impressions. Of course what I saw there is not peculiar to California, but it is far from here and could be viewed with some detachment of feeling. It is one of the two or three most progressive of our states, in education, in public health, in child welfare, in social legislation, in social consciousness. This plus natural beauty and fertility and productivity of the highest. And one finds not an industrious, contented, smiling people, but a frightened, bewildered and restless one; faces are unhappy and hopes not too high. And, obviously, much the same thing is to be seen and felt here or any where in the country. What is wrong? Many things, perhaps mostly social forces beyond our control. But it does seem that pediatricians and psychiatrists might decide what their place is in this world.

We can bury ourselves in our jobs, and do what lies before us for the next hour or day, whether this be seeing patients, or doing research, or teaching or any of a number of forms of activity. Most of us would prefer to continue in our daily routine, but the pressure of government and other organizations upon us becomes steadily greater. If we pause to survey, with a

"Whither are we drifting?" attitude, we must wonder what goes on. In medicine, as in industry or politics, our tendency has been to hail anything new as progress and all progress as good. Few question that the electric light, the automobile, airplane, telephone, radio and movie are benefits to humanity. Few question that all medical, psychological, and educational discoveries also are benefits. But, in the same period in which these discoveries (and many of them so amazing as to seem superhuman) have been given to us, we have almost lost our capacity to live. It probably is not cause and effect, but it may be. Doesn't it seem desirable that medicine, instead of catapulting itself forward along with the rest of the world, might be more thoughtful and pause to evaluate its trends?

By now a whole generation has been raised with the "New Understanding." They are taller, their hands and feet are bigger and dentists tell us their teeth are better. But it is surely an optimist who would say that they are better, in the whole range of their lives, than their parents or grandparents. Are the things that we do when we solve or attempt to solve our children's problems helping them through life? Can a child be guided — where? Even though we had an end in view, which we haven't, could we get a child safely to this goal? Mussolini, Stalin, and Hitler are trying this. It was tried with the Duke of Windsor and didn't work. Does anyone know how to raise a child? Have we, by increasing our knowledge of children's reactions, emotions and tendencies, only added to the burdens they must carry? Is it possible that too many people are getting too interested in children?

The parents I see are sadly bewildered. They are self-conscious with their children. They are trying too hard for them, trying too hard for their happiness and success. A child comes into the room, sits on his mother's lap a few moments, then turns and socks her a good one on the face. She is afraid to react — she may repress the child — he may grow to hate her, so she turns to me, in a voice quiet but trembling, and asks "What shall I do?" And I of course don't know.

In education and some fields of medicine, as in politics, people who know how to get quickly

to the top are formulating ideas, principles, plans for others to follow. We should by now know what happens to the best made plans. Much of the difficulty lies perhaps in the personalities of those who are in high places. They are smart enough but seem woefully immature. They have learned to talk in gentle, humanitarian, understanding phrases, but understanding is a rare attribute. They seem peculiarly susceptible to two common conditions, power-hunger and publicity-hunger. And they cease to hear and feel and take in, but only give out. These traits are not helpful in a frightened community. Ideas pour from these sources, and many perhaps are good ideas. Whether they are so good when they pass into our lives or into children's lives we cannot but doubt. Ideas and plans for the welfare of doctors or farmers or children need organizations and organizations lead to things that many of us don't like. We are given the assurance that if every mother had prenatal care, trained assistance at delivery, every child taken to a welfare clinic, every youth educated, every adult assured an income and medical care, great strides forward in civilization would be made. I am skeptical. Are we, through our present day culture — our education, our solicitation for every child's emotional and mental and physical welfare helping them, or are we tending to produce, or to stand by and see produced, a generation that "can't take it" and waits only for a powerful leader to appear with promises of security? And when I say they "can't take it" I don't imply that they are weaklings — there may just be too much to take. The world grows tougher — had we better try, or can we toughen our children to meet it?

If this sounds defeatist I've made a wrong impression — there would be no interest and no fun in pediatric practice if one carried the world's burdens wherever he went, but there are powerful and terrifying forces pressing upon us, and I do think it well to take cognizance of these in any discussion of children's lives.

## Conclusion

### Dr. Kahn

I don't think I have anything materially to add to what our five colleagues have told us. I

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(Continued on Page 48)



# The Relation of the Autonomic Nervous System to Pharmacology\*

ABRAHAM MYERSON, M.D., Boston, Mass.

1. **General principles:** The autonomic nervous system manufactures chemical substances which regulate visceral activity. The autonomic activity is the resultant of three sets of chemical substances: (1) sympathin which is the active agent in bringing about what are here called adrenergic effects and which is mainly formed at the junction between the second sympathetic neuron and the reacting cell. (2) Acting in a balance to this chemical is acetylcholine which is mainly produced by the parasympathetic neurons and operates at the junction between the neurons and the junction of the second parasympathetic neuron and the reacting cell. (3) Cholinesterase is an enzyme, the function of which is to hydrolyze or destroy the acetylcholine. It is present in the tissues and in the blood, and acts so as to render the activity of the parasympathetic enzyme, acetylcholine, intermittent in its activity. Thus, there is a balance, on the one hand, between the adrenergic substances of the sympathetic nervous system and the cholinergic substances of the parasympathetic nervous system and, on the other hand, a more local balance between the acetylcholine and the esterases.

2. **Drugs:** The drugs used have been selected because of their potency and the predictability of their results. The adrenergic substance used is benzedrine sulphate (benzyl-methyl carbamine or Beta-phenyl-isopropylamine) and the cholinergic substance, mecholyl (acetyl-beta-methylcholine chloride). These drugs are relatively balanced in their activities, although not entirely. Prostigmin (dimethyl-carbamic ester of m-Oxyphenyl-trimethylammonium methylsulphate) is used to destroy or inhibit the esterases, so that the drug is a powerful synergist of mecholyl. The function of atropin (mandelic ester of tropine) in these experiments is to lessen or block the activity of mecholyl or of acetylcholine, and

consequently to act as a synergist to benzedrine. There is lacking in this series of experiments something which will paralyze the sympathetic, but no drug has, as yet, been developed which safely performs this function.

3. **General plan:** The general principle of the work done has been to study organ by organ the body of human beings who, though suffering from mental disease, are organically healthy insofar as our present day knowledge goes. For this purpose dementia precox patients have been utilized.

1. **The eye:** By instillation of these drugs into the eye, the results which have been obtained show the following:

(a) The palpebral fissure is narrowed by cholinergic (mecholyl, prostigmin) stimulation, widened by adrenergic (benzedrine) stimulation. These results undoubtedly are due to a local effect upon Muller's muscle.

(b) The pupil is a balanced function, cholinergic substances (mecholyl, prostigmin) narrowing the pupil, adrenergic substances (benzedrine, etc.) widening it. By paralyzing the parasympathetic through atropin, the pupil is widened. Atropin acts as a synergist to benzedrine in this capacity. Prostigmin is a synergist to mecholyl.

(c) The light reaction is a balanced function between darkness and light stimulation, and chemically between cholinergic (mecholyl) and adrenergic (benzedrine) stimulation.

(d) The intraocular pressure is a balanced function, cholinergic substances lowering the tension, adrenergic substances increasing it.

(e) The lens, although anatomically innervated by the parasympathetic, may be increased in its capacity to accommodate by cholinergic substances (especially by prostigmin), and less-

\*Abstract of paper presented before the Hartford County Medical Association at Bristol, October 25, 1938.

sened in its capacity to accommodate by adrenergic substances and atropin.

(f) **Argyll Robertson pupil:** The principal defect in the Argyll Robertson pupil is an incapacity, or loss of the full power, of sympathetic activity although the parasympathetic is to some extent involved. By adding adrenergic substances (benzedrine sulphate  $\frac{1}{2}$  to 1 per cent) the pupil dilates and becomes moderately reactive to darkness and to daylight.

(g) **Presbyopia:** By the use of prostigmin in a preliminary stage the presbyopic eye becomes myopic. In a short time it becomes emmetropic. In this case the capacity of the lens to react to the near point became that of a man of 35, the actual age of the individual being 55.

2. **Sweat, flushing, etc.:** Sweat, flushing and rhinorrhea appear to be cholinergic functions, despite the fact that the structures involved are sympathetic in innervation. Under mecholyl, sweating, flushing and rhinorrhea become very marked. Prostigmin acts as a marked synergist to these reactions of mecholyl.

(a) **Local sweat:** The sweating produced by mecholyl is alkaline. Furthermore, by introducing mecholyl into the skin an interesting local sweating is caused, which is alkaline. This sweating is stopped by the previous use of atropin, is increased by the previous use of prostigmin and is not affected by benzedrine.

3. **Gall bladder:** Atropin sulphate markedly affects the emptying time of the gall bladder after a fatty meal, as shown by the silhouettes which are duplicates of the X-rays. Benzedrine sulphate does not affect this emptying time for a period of two hours after the injection of the drug. At the end of that there is a marked hold-up of the emptying reactions.

4. **Heart and blood pressure:** Mecholyl in small doses stimulates the pacemaker which is more of an adrenergic than a cholinergic function, and at the same time decreases the conductivity so that the P — R interval is lengthened. Heart block is with difficulty obtained by mecholyl alone unless excessive doses are given. Prostigmin slows the pacemaker somewhat and lessens the conductivity of the bundle of His so that the P — R interval is lengthened. The addition of prostigmin to mecholyl produces extraordinary and marked effects on the heart so that the pulse

becomes very slow and heart block, even asystole, may be brought about. Atropin immediately checks the effects of mecholyl or prevents them from coming about if given in advance. By itself it stimulates the pacemaker. Benzedrine sulphate appears to have no definite effect upon the conducting mechanism of the heart, although the pulse rate becomes somewhat slower.

5. **Blood pressure:** The blood pressure is apparently a balanced function insofar as autonomic pharmacology is concerned. Benzedrine sulphate given in large doses either by mouth or subcutaneously raises the blood pressure very markedly. It tends to raise the blood pressure against the depressing effects of amytal narcosis. Mecholyl lowers the blood pressure markedly, but for a short time. Prostigmin, having little effect itself, is a marked synergist to mecholyl. Atropin paralyzes or prevents the effects of mecholyl and acts as a synergist to benzedrine. The combination of prostigmin and mecholyl, as well as the combination of benzedrine and atropin, produces results which must be carefully watched.

6. **Gastrointestinal tract:** Mecholyl has a marked effect on the atonic intestinal tract. In one case, it ordinarily took 12 days for the barium enema to make the transit. Mecholyl speeded the process so that within five minutes the intestinal tract was tonic, and this increased tonicity lasted 24 hours. Physostigmin has a similar effect, as shown on the dog's stomach. Benzedrine relaxes spasm of the gastrointestinal tract, whether of functional or organic origin. Aside from the therapeutic value, it is of great help to the X-ray man in clearly defining lesions and in differentiating between functional and organic spasm.

7. **Urinary bladder:** Mecholyl by itself has little effect on the urinary bladder. The combination of mecholyl and prostigmin produces a marked contraction of the dilated bladder, in this case to about one-third of its original capacity. Atropin stops this effect and restores the bladder to more than normal size. Benzedrine sulphate relaxes the bladder, in which it is aided by atropin.

8. **The synergism of prostigmin and mecholyl:** This is illustrated by the effect on blood pressure, heart activity, and the secretion



of the juices of the stomach, as well as the sweating reaction, the urinary bladder, and in practically every function which is involved by the use of mecholyl, including the eye.

9. **Esterases:** The evaluation quantitatively of the esterases has proceeded to the point where it is now a routine procedure in our laboratory, as well as in other places. The technique which depends upon the hydrolysis of acetylcholine by blood serum has been standardized and is not difficult.

10. **Iontophoresis:** Iontophoresis is the introduction of chemical substances by the use of the galvanic current into the skin. On the positive pole, there is placed the substance to be introduced; on the negative pole, the salt solution. Blood pressure can be continuously and quite markedly reduced by the iontophoresis of mecholyl. The gastric juice can be maintained at an alkaline condition for a long period of time and without the general untoward effects noted when mecholyl is injected intramuscularly. Prostigmin enhances the iontophoresis of mecholyl. Atropin blocks it. Benzedrine sulphate may be introduced by iontophoresis to produce the usual benzedrine results. The method has the advantage of a slow and continuous introduction of chemical substances into the body.

**Summary:** It may be stated that many functions of the human organism may be manipulated at will, in a predictable and quite marked manner, by the use of the autonomic drugs mecholyl, benzedrine, prostigmin and atropin.



### PLAN FOR PREPAYMENT MEDICAL BILLS

The Cleveland Academy of Medicine is considering a plan for the prepayment of medical bills by persons covered by the Cleveland group hospitalization plan. The essential features of the plan are a payment of \$6.00 per day to provide for medical services and the privilege of choosing any physician licensed by the State of Ohio.

### COURSE IN OBSTETRICS AND GYNECOLOGY TO BE GIVEN AT THE YALE UNIVERSITY SCHOOL OF MEDICINE

The Department of Obstetrics and Gynecology of the Yale University School of Medicine announces a course for members of the State Medical Society. The course is open to those interested in Obstetrics and Gynecology, but has been especially arranged for the practitioner of general medicine. It will consist of six conferences upon clinical problems in Obstetrics and Gynecology. These conferences will be held in the New Haven Hospital from 3:00 to 5:00 P.M. on Friday of each week commencing February 17, 1939. During the first hour a specific subject will be discussed. The second hour will be occupied in the general discussion of clinical problems presented by the leader of the conference or by members.

The number accepted for the group will be limited by the facilities available. Members of the Society who wish to attend the conferences should apply to the Department of Obstetrics and Gynecology, New Haven Hospital, before February 1, 1939.

A fee of \$10.00 will be charged.



### ASPHYXIA OF THE NEWBORN

Five out of every hundred babies born alive die within the first twenty-four hours of life. Birth registration statistics show that about 80,000 infants die annually at birth in this country; 30,000 more die on the first day of life from causes originating at birth. The principal causes of death during the first twenty-four hours of life are prematurity, cerebral hemorrhage and asphyxia.—*J. A. M. A., Nov. 26, 1938.*



### FIRST ANNUAL INDUSTRIAL HEALTH CONFERENCE

The first Annual Congress on Industrial Health, sponsored by the American Medical Association will be held at the Palmer House, Chicago, January 9 and 10. The program includes addresses by representatives of the A. M. A., the American Association of Industrial Physicians and Surgeons, the American College of Surgeons, the American Public Health Association, several Federal departments and medical departments of large industrial plants.

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## Gonorrhea in the Female\*

ROY W. MOHLER, M.D.

Philadelphia, Pa.

In my discussion I shall outline the management of gonorrhea in the female. Since my interest in gonorrhea is clinical. I shall confine my remarks to a clinical consideration of the subject.

Gonorrhea may be observed in three periods during the life of the female, and in each period it produces certain clinical manifestations which are characteristic for that period of time. We may observe the infection before puberty, at which time it is known as gonorrheal vulvo-vaginitis, during the reproductive period and following the menopause. The variation in these manifestations is caused by the specific action of the infecting organisms on various types of epithelium. These types of epithelium are produced by endocrine changes which are characteristic during certain age periods.

### Vulvo-vaginitis before puberty:

Certain features of gonorrheal vulvo-vaginitis before puberty are fairly well understood at the present time, and the treatment has been pretty satisfactory since your neighbor and Fellow, Dr. R. M. Lewis introduced it a few years ago. There is still some controversy as to whether the estrogenic hormone should be given in large doses intramuscularly, or whether it should be used in suppositories. I have had no experience with the suppositories, but have had very good results with the use of large doses of the hormone intramuscularly. The dosage which I have used is 2000 International Units daily until the reaction of the vaginal secretion has become acid, and the vaginal flora has developed into the type noticed in the normal adult. I have used no local treatment except cleanliness about the external genital tract which is accomplished by the use of Neko soap and boric acid solution on cotton sponges. I am inclined to think that topical applications to the vaginal canal and cervix is not good treatment. First, it is bad from a

psychological standpoint for the patient, and second, it is likely to destroy the epithelium of the vaginal tract which seems to have a protective function against the infection. At Jefferson Hospital in the Pediatric Department, Dr. J. H. Holmes has treated a well controlled group of 51 patients with sulfanilamide in various forms. His studies have been rather complete, but the results, according to Dr. Holmes, have not been satisfactory.

There are a number of problems connected with vulvo-vaginitis which are quite important and which I think have not been explained. The source of the infection is often very difficult to determine and very often cannot be explained satisfactorily after most careful investigation. Are these infections really gonorrheal in origin, or are they infections with an organism which morphologically resemble the gonococcus? I really think that until the time when Lewis introduced his treatment traumatism induced by treatment had much to do with the persistence of the infection. It was then the custom of many men to paint the whole of the vaginal tract with 5 and 10% silver nitrate solutions, or to instill into the vaginal canal concentrated solution of argyrol. I have on a number of occasions removed from the vaginal canal of girls with so-called vulvo-vaginitis large deposits of epithelium caked in argyrol and found that after this simple procedure the vulvo-vaginitis had subsided.

In the management of vulvo-vaginitis in the female before puberty it must be remembered that the endocervix has not developed to its adult type and that the accessory tubules about the external genitalia are very immature, or entirely undeveloped, depending upon the age of the individual. It must also be appreciated that the extension of the infection to the internal generative organs almost never occurs. This can be explained because of the lack of development of the uterus, tubes and ovaries, and also

\*Read at the Annual Meeting, Connecticut State Medical Society, Groton, June 1-2, 1938.



because of the absence of treatment directly to the cervix and other traumatic influences.

### **Gonorrhea During the Reproductive Period:**

Gonorrhea during the reproductive period of the female may be an acute diffuse infection of the external genitalia when observed early in its course, or it may be a latent or chronic infection when observed late in its course. The acute stage of gonorrhea is usually easy to diagnose by a complete history and an examination of the parts affected. The history of the patient suspected of having gonorrhea should be complete and candid; sometimes it must be secured without allowing the patient to know her suspected illness. Intimate details of sexual contact must be known and something should, of course, be known about the male partner, and this can often be better secured from the physician who treats him than from the individual himself.

Usually the symptoms of an acute gonorrheal infection begin from one to seven days after exposure. They are often mild and not characteristic. There is some irritation about the external genitalia with burning and itching. The urethra is usually involved which produces incontinence and dysuria; the Bartholin's glands, if infected, will cause pain and discomfort. A vaginal discharge may be present but, unless it has developed in an individual as a recent occurrence, will have very little significance so far as a specific symptom is concerned. The symptoms may be so mild and transitory that they have escaped the notice of the patient unless something occurs which calls her attention to her slightly unusual condition.

### **Examination of the Patient:**

The patient should be instructed to empty her bladder before she is arranged on a suitable table for gynecological examination. If the patient empties her bladder immediately before pelvic examination the ureters will have been cleared of epithelial cells and degenerated pus cells. Light for the examination must be good. It has been my custom to use a head mirror and reflected light for all gynecological examinations. Skenes' tubules, the urethra and Bartholin's glands are minutely inspected and after a thorough investigation for evidence of infection the secretion is removed from the vestibule of the vagina and from the urethral glands and transferred to a polished glass slide by means of

a plain wooden or metal applicator. The applicator should not be wrapped with cotton because of the confusion which the cotton fibres may cause in the study of the smear. In the presence of acute gonorrheal infection smears taken from these areas will contain many pus cells and many Gram negative intracellular diplococci and a few contaminating organisms. In the presence of latent gonorrheal infection the smears may contain only a moderate number of pus cells and some epithelium and, after diligent search, usually a few Gram negative intracellular diplococci. The examination of the smears should be made by the individual responsible for the clinical management of the patient, or under his direct supervision. If this rule is carried out I think that the results will be much more satisfactory. If the gonococci are found in smears from the vestibule of the vagina and urethra no further examination is necessary to make the diagnosis; a more complete examination may spread the infection from the external genitalia to the endocervix which may be free of the infection.

### **Treatment of Acute Gonorrhea:**

The treatment of acute gonorrhea is based on two premises: the first, that gonorrhea is probably a self-limited disease and in the female localizes in the urethral glands, the endocervix, and in Bartholin's glands where it remains latent for an indefinite period of time; the second, to prevent so far as possible the extension of the infection to the uterine adnexa and pelvic peritoneum. If we assume that this concept of the infection is correct, treatment should be outlined so that localization will occur promptly and so that extension of the infection will not occur. These aims may be accomplished usually by the following plan: a simple sedative should be given the patient, such as phenobarbital,  $\frac{1}{8}$  grain, and sodium citrate, 30 grains, every four hours; this mixture will alkalinize the urine and prevent some of the discomfort of which she may complain. Local treatment should consist of keeping the parts clean with some mild antiseptic soap and a vaginal douche of bicarbonate of soda (tablespoonful to one quart of warm water) once or twice daily. The douche should be given with the patient in the supine position with her hips slightly elevated and the water container placed 24 inches above her body.



High-pressure douches are absolutely to be avoided. Specific directions should be given the patient to avoid all types of physical exertion or activity which would increase intravaginal pressure, such as coitus, dancing, swimming, diving, heavy lifting and sexual stimulation. Topical applications of antiseptics to the infected areas should be avoided because of the danger of causing an extension of the infection to the internal genitalia and because the antiseptics may inhibit the natural reaction of the tissue to the infection. Our aim in the management of these patients should be to aid them and their own forces to overcome the acute infection. Good food, plenty of rest and thorough elimination from the bowel daily are necessary adjuncts to this routine. Constant rest in bed does not seem necessary in most instances and very often it is not practical from an economic point of view.

In a discussion of the treatment of acute gonorrhea in women mention should be made of sulfanilamide. I have had no experience with it personally. I feel, however, that from the experience of others, that I shall not substitute it for my present plan. Theoretically, I do not see how it can exert much effect on a local or focal infection. I do think, however, that if it is without harm and if one chooses to use it in the hope it may have some good effect, it may prove to be good treatment.

After a few weeks, or longer, of the routine I have outlined the acute infection will have become latent, the symptoms will have subsided and the patient will not be conscious of her trouble. In treating acute gonorrhea in women as outlined, I have recognized that it is essentially a self-limited infection and that our whole problem in the acute stage is to make the diagnosis and to prevent as far as possible the extension of the infection to the internal genitalia.

In discussing acute gonorrhea there is always the important problem of management of the infection during pregnancy, during which time it must occur quite frequently. It is, however, not often recognized and therefore no treatment is instituted. The patients whom I have seen and recognized as having acute gonorrhea during pregnancy have shown no tendency to remission and the external genital tracts have indicated constantly the typical reaction to the infection. Smears were positive throughout the course of pregnancy and many of these patients have rup-

tured their membranes prematurely. I have not seen any cases of acute pelvic inflammatory attacks from the infection during pregnancy and I believe if our concept of the mode of extension of gonorrheal infection is correct, that it could not occur. So far as the management of the acute infection during pregnancy is concerned, I think it should consist of simple means of cleanliness without local applications. Sometimes a simple douche will be necessary to clear the vagina of an excessive secretion. During labor and the puerperium every precaution must be taken to prevent extension of the infection. After the puerperium the management of the infection is no different from the usual procedure.

### **Latent Gonorrhea:**

Latent gonorrhea is the type of infection which is most often seen during the reproductive period. It is the term used to describe the infection after it is localized in Skene's tubules, the urethral glands and the endocervix. Latent gonorrhea may be seen immediately following an acute infection which has been observed throughout its course, or it may be observed sometime after the acute infection has subsided. The infection in these focal areas may persist indefinitely unless very active means are used to destroy it and so long as the focal areas persist the patient is infectious to herself and to her consort.

### **Diagnosis of Latent Gonorrhea:**

The diagnosis of latent gonorrhea is much more difficult than in the acute cases. This is especially true when there is no known history of an acute infection. The history of the sexual habits of the patient are important when they are accurate. When a patient gives the history that she has infected her consort, it is very important information. I shall site the history of one such patient. Mrs. B., a divorcee, was sent to me by a urologist who had made the diagnosis of gonorrhea in her consort. Mrs. B. had had an attack of salpingitis four years previously and apparently had an untreated infection of her lower genital tract, which was contracted from her husband at that time. This patient separated from her husband and received a divorce. A few years after her separation from her husband she became the consort of the man whom she expected to marry. Sexual intercourse had been practiced for some time without prophylaxis and no infection occurred. Finally, just

before consulting me, she had infected her consort. There had been no other sexual contact by either of these individuals during this period of time and the source of the infection was quite definite. At my examination there was much pus in the secretion from Skene's tubules and from the cervix. No gonococci were seen. The Skene's tubules were easily isolated and the cervix was found to be badly diseased and everted. In spite of the fact that smears from this patient did not show gonococci, the latent infection of Skene's tubules and the cervix, together with the history of the patient, which was very definite, made the diagnosis clear and easy to make.

### Examination of the Patient:

Smears should be made of the secretion taken from the urethra and from the cervix after the bladder has been emptied. To obtain smears from the urethra, it is massaged vigorously against the under surface of the symphysis and the expressed secretion transferred to a glass slide. If no organisms or pus cells are observed in the smears taken at the first examination it should be repeated in twenty-four hours. Very often the trauma produced by the first examination will cause enough tissue reaction so that twenty-four hours later organisms or pus cells can easily be discovered. The presence of pus cells in the smears taken from the urethra is very significant of a latent gonorrheal infection and if one is persistent enough and thorough in examining the smears, gonococci are almost sure to be seen in most cases. Smears of secretion from Bartholin's glands should also be secured and studied. These glands frequently show no evidence of infection in the latent cases of gonorrhea. If infection should exist in them, there is usually observed on close inspection some redness about the orifice of the glands and the secretion from them will be slightly cloudy instead of the clear glistening mucus.

The smears from the cervix should be taken with the utmost care. The cervix is exposed and all of the vaginal secretion gently cleaned from the portio and the secretion from the cervical canal transferred to a glass slide by means of an unwrapped wooden applicator, or wire loop. The presence of pus cells in the smears indicates an endocervicitis which may be gonorrheal in origin. The gonococci are sometimes quite difficult to find in the latent cases, but usually with

care an occasional organism can be discovered. A good working premise is that a latent endocervicitis which accompanies a latent infection of the urethral glands is gonorrheal and the infection must be treated accordingly.

It is very bold to say without more proof than we have at present, but I believe from clinical observations that persistent latent infection of the urethral glands is almost always of gonorrheal origin and in most instances that persistent foci of infection in the urethral glands are most responsible for re-infection.

### Treatment of Latent Gonorrhea:

After the infection of Skene's tubules and the urethral glands has been proven, the tubules are isolated with small probes which can be inserted into their ostia. The urethra is then anesthetized with a 10% solution of cocaine hydrochloride applied to the urethral surface with a cotton-wrapped applicator which is allowed to remain in the canal for five minutes. After the urethra has been properly anesthetized either a small tip cautery, or the electrode of a Diathermy generator is inserted into the isolated tubules, and each tubule is then coagulated. Complete healing of the coagulated area occurs in about twenty-one days, after which a careful search for other foci about the urethra should be made, and if any are found destroyed in the same manner.

At the time of the treatment of the urethra, the cervix is exposed and the infected endocervical tissue is destroyed. This may be accomplished by simple cauterization, coagulation, or endocervical resection. No anesthetic is required for cauterization or tissue coagulation of the cervix; however, an anesthetic is necessary for endocervical resection. Cauterization of the endocervix is by far the most easily accessible means of treatment, but does not always seem to be so adequate as the other procedures. The reason, perhaps, is that not enough of the endocervical tissue can be destroyed without the occurrence of stenosis. Tissue coagulation seems to be a very satisfactory method with most patients. The electrode should be about 2 mm. in diameter; the current used should be adjusted so that carbonization and too deep destruction of tissue do not occur and the whole of the circumference of the cervical canal coagulated for about three-quarters of its length. Endocervical resection may be undertaken and accomplished



by the method described and popularized by Hyams, or it may be done by the operation described by Sturmdorf. Both of these methods are effectual if properly executed. They require, however, the facilities of an operating room and a general anesthetic, and certainly, in most instances, the other procedures will be quite as satisfactory.

The treatment of Bartholin's gland when it becomes necessary is sometimes a difficult problem. As a rule an abscess develops which must be incised and drained. If the whole of the gland has been destroyed by the infection, the area closes by granulation and no residual infection remains. If part of the gland remains, however, after the infection and the duct is closed, another abscess may form or a Bartholin's cyst may develop.

After the destruction of the focal areas of infection, the patient should be instructed to carry out the same routine as prescribed for acute gonorrhea. The treated areas should be examined once or twice weekly, and if the slough seems to be preventing drainage of the parts, it should be separated very carefully.

A profuse offensive discharge follows these treatments in about four days and some bleeding may occur when the slough separates. These symptoms may persist for ten days and may cause the patient considerable anxiety. They are, however, the natural sequence of the treatments and can be managed usually without difficulty by warning her to anticipate them.

Complete evolution of the treated areas occurs in about four weeks. The treated Skene's tubules and urethral glands are replaced with fibrous tissue and their location is covered with squamous epithelium. The destroyed endocervix is replaced largely with squamous epithelium of the vaginal type. During evolution of the treated area of the cervix there is a potential danger of stenosis occurring. This, however, does not occur frequently unless the treatment has been too vigorous or of a fractional type. If it should occur, its management becomes a problem which cannot be considered here.

Any discussion of gonorrhea in the female must include a consideration of salpingitis and its natural sequela, pelvic inflammatory disease. Most of the clinical investigations on gonorrhea in the female have concerned consideration of

pelvic inflammatory disease. In my outline for the management of lower genital gonorrheal infection I have tried to emphasize the importance of doing things for the patient which will prevent pelvic inflammatory disease. These directions, if carried out in detail, will prevent much of the pelvic inflammation which is commonly seen. The diagnosis and pathology of gonorrheal pelvic inflammation are quite well understood and there is no need to cover these points in this discussion. There are, however, a few points which I think are worth mentioning because I do not believe they are generally appreciated.

First, I wish to repeat that management of the patient with lower genital tract infection is most important since all pelvic inflammatory processes of gonorrheal origin develop from a focus in the lower genital tract by continuity of tissue surface. The second point is that initial attacks of pelvic inflammation usually will subside without producing many permanent changes by the simple conventional means of treatment, such as rest in bed, sedatives and general nursing care, and that following the initial attack repeated attacks can be prevented by destroying the foci of infection in the external genitalia.

After repeated attacks of pelvic inflammation extensive changes are produced. It is this particular type of patient which may be seen in the hospital and on whom all types of therapy are given some trial and for entire relief, operation and complete removal of the internal genitalia is often necessary. These patients have been treated with hot vaginal douches, foreign protein injections and diathermy by the Elliot method. At the present time, hyperthermia by the Kettering machine, or some modification of it, seems to be the treatment of choice. Men who have treated large series of cases by hyperthermia have reported excellent results and are most enthusiastic about it. The methods at our disposal overcome the infection in most instances but have very little or no influence on the adhesions, discomfort and mal-function produced by the involuntary processes which occur after the infection has subsided.

It is very difficult to change thoughts in medicine as it is in our social and political order. We develop habits of thought and living and any sudden change in either is likely to produce ruin or revolution. Any change which takes place



must be an evolutionary process and must be made gradually. This bit of philosophy expresses very well what has happened in our concept as to how gonorrheal salpingitis and pelvic inflammation should be treated. Not so many years ago every acute pelvic inflammation was operated upon as soon as recognized. Since that period methods of management have become more conservative until now it is almost the rule never to operate for pelvic inflammation. When operation is necessary it is usually done for the sequelae of the inflammatory process.

After an attack of pelvic infection of gonorrheal origin has subsided, all foci of infection in the lower genital tract should be treated and cleared of the infection. This statement applies to the patient who has had extensive pelvic operations for the relief of her symptoms as well as the patient who has had her first attack of pelvic inflammation.

To know when patients are cured and when it is safe for them to resume sexual relationship is the most important obligation one assumes in the management of gonorrhea in women. The disease can be cured and we must have some standard for proof of cure. The conventional standard for proof of cure based on the absence of the gonococci in three sets of smears taken at various intervals is very unreliable because occasional organisms, which could easily be missed in a very careful examination of smears, might well be responsible for a new infection in the individual or her consort. The complement-fixation test is not sensitive enough to determine lower genital infection. Cultures for the gonococci are practical in selected cases, especially in the acute attacks in the adult and in the vulvovaginitis of childhood.

The resident at the Methodist Episcopal Hospital in Philadelphia, Dr. William F. Hartman, has been using a chocolate North gelatin agar, with blood as the culture media in a high concentration of carbon dioxide.

The method to determine cure, which is applicable in most cases, is one which I have used for a long period of time in my own work. I have

been able to check on it a number of times and have come to regard it with considerable confidence. The method is based on the premise that the secretion from a non-infected urethra, Bartholin's gland, or cervix contains no pus cells. The reaction of these areas to the gonococci is an inflammatory one and the secretions will therefore contain pus when infection is present. Smears are made at intervals of the secretions taken from these focal areas with considerable care and each smear is examined for pus cells. If the smear contains pus cells, I presume that the patient is not cured and further treatment and observation are necessary. Conversely, I presume that if pus cells are absent in the smears taken from these areas, no inflammation is present and the patient is no longer infectious. This whole course of treatment and observation will require considerable time, very often six months or more.

### Conclusions

I have given you my views as to how gonorrhea in the female should be managed. They are based on the following conceptions:

1. That gonorrhea is in most instances a self-limited infection; the acute infection subsides promptly, the latent infection may last indefinitely, but, barring re-infection, it will probably subside spontaneously after longer periods of time.

2. That infection of the Fallopian tubes and pelvic peritoneum can be prevented in most instances if no active treatment is undertaken in the acute attack of external genital infection, and if the patient is directed to avoid physical activities which increase intra-vaginal pressure.

3. That the focal areas of infection in the external genital tract usually must be destroyed in latent gonorrhea and that the patient is infectious until no evidence of infection is present.

4. That the absence of pus cells in the secretions from the lower genital tract is the best proof that these patients are no longer infectious and therefore are cured.

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## Immunization With Scarlet Fever Toxin

GEORGE A. WULP, M.D.

Hartford, Conn.

During the early part of 1938 there were several cases of Scarlet Fever at the Newington Home for Crippled Children. The first few cases were from one dormitory which we had kept isolated after the first case in the hope of confining the spread to that room. However, one of the children in another dormitory eventually did contract the disease and we were then faced with the problem of how to control the spread and also prevent, if possible, future outbreaks.

Our situation was such that, while we might be able to isolate one dormitory in the hope of confining the cases to that room, once other dormitories were affected isolation of contacts became impracticable. All actual cases were sent to the Isolation Hospital in Hartford, as we had no facilities for the care of contagious diseases.

The matter of active immunization of all Dick positive children was discussed with members of the State and Hartford Health Departments. Since they had recently completed a survey of the literature on this subject they were in a position to give valuable aid. According to the figures shown in their abstracts, active immunization with Scarlet Fever Toxin had yielded good results, and therefore we felt justified in using this procedure. We had also considered passive immunization of all Dick positive children, since by this procedure we might have more chance of halting the current outbreak. However, immunity apparently develops rapidly also with the Toxin; in addition, active immunity outlasts passive immunity and in a semi-permanent population such as we have in the Newington Home for Crippled Children this would help to prevent future outbreaks. The idea of using passive immunity was therefore discarded.

Accordingly, all children at that time resident in the Newington Home for Crippled Children were Dick tested. Of 166 children, ranging from nursery to high school age, 118 gave positive reactions and one of these positive reactors de-

veloped Scarlet Fever before we started active immunization. Of the remaining 117 a few were discharged prior to completion of the course or before re-Dicking was done. We employed the method recommended by the Scarlet Fever Committee, namely, 500 S.T.D. for the first dose, followed by 2000, 8000, 25,000 and 80,000 to 100,000 S.T.D. at subsequent injections, with the following modifications: half of the children were to get the full recommended dose, and the remainder half the recommended dose; furthermore, the final dose was to be given in two injections of equal strength. All material was given subcutaneously. The doses were split in order to check the reactions which might occur and to decrease their number. After the first two doses it was found that the reactions were neither sufficiently severe nor frequent to warrant continuing this routine and from then on all children received the full recommended doses. Immunization was started on March 2nd, 1938 and injections were given weekly thereafter until completed.

Our results are as follows: Of the 117 children who were given the toxin, 7 were discharged either before completion of the series or before the time set for retesting their reaction to another Dick test. There was a total of 767 injections of toxin given and of this number 74 had reactions which were manifested by slight malaise, slight or no elevation of temperature and vomiting. Three had severe reactions consisting of fever, rather severe malaise and more persistent vomiting. None of the reactions lasted more than 24 hours. The total number of reactions, 10% of the doses given, approximates the figures found by most of those whose articles have been reviewed. We were pleasantly surprised to find that all but three of the reactions were comparatively mild. None were severe enough to warrant withholding the toxin.

On May 11th, 1938, 111 of these children were again given the Dick test. Seventy-six, or 68.5% were found to be negative while thirty-five, or



31.5%, were still positive. On October 8th, 1938 twenty-two of the thirty-five positive reactors were again given the Dick test; eighteen of these were still positive, while four had become negative. These results show a lower percentage of children with a reversal of the Dick test from positive to negative following the use of toxin as an immunizing agent than is obtained by most of those whose reports have been seen.

Since this series was started there has been only one case of Scarlet Fever at the Newington Home for Crippled Children and this case was in a child admitted subsequent to our series and who had not as yet been Dick tested.

Although the results obtained in our series does not show as high a reversal of Dick tests following active immunization with Scarlet Fever Toxin as one might expect from the literature, still we believe it is sufficiently high to warrant its use in institutions where an outbreak of Scarlet Fever may so readily become serious. It is possible that had we given those children who were still Dick positive after the regular series a repeat dose, as recommended by the Dicks, we might have had a higher percentage of negative re-Dicks.

We feel that the reactions encountered in our series are neither numerous enough nor of sufficient severity to warrant withholding the toxin under conditions where it is indicated.



### MONOPOLY IN REVERSE

The Houston (Texas) Post in a very timely and terse editorial calls attention to the inconsistencies of the present suit brought by the government against the American Medical Association. In that part of the country, at least, this action is considered as a direct threat to the average citizen's own family physician. "To invoke such (anti-trust) laws against the American Medical Association," the Post says, "appears to be a somewhat screwy proposition to the average American, who is unacquainted with the methods used to make black white and white black, when facts or some law stand in the way of a cherished governmental objective. In this instance, the objective seems to be socialized medicine, which would mean regimentation of the medical profession, saddling of another huge tax burden on the people, and a decline in standards of medical profession."

### AMERICAN BOARD OF OPHTHALMOLOGY

The American Board of Ophthalmology announces an important change in its method of examination of candidates for the Board's certificate.

Examinations will be divided into two parts. Candidates whose applications are accepted will be required to pass a WRITTEN examination which will be held simultaneously in various cities throughout the country approximately 60 days prior to the date of the oral examination.

The WRITTEN examination will include all of the subjects previously covered by the practical and oral examinations.

ORAL examinations will be held at the time and place of the meeting of the American Medical Association and of the American Academy of Ophthalmology and Otolaryngology, and occasionally in connection with other important medical meetings. The ORAL examination will be on the following subjects: External Diseases, Ophthalmoscopy, Pathology, Refraction, Ocular Motility, Practical Surgery.

Only those candidates who pass the written examination and who have presented satisfactory case reports will be permitted to appear for the oral examination.

Examinations scheduled for 1939: WRITTEN: March 15th and August 5th. ORAL: St. Louis, May 15th; Chicago, October 6th.

Applications for permission to take the written examination March 15th must be filed with the Secretary not later than February 15th.

Application forms and detailed information should be secured at once from

Dr. John Green, Secretary  
6830 Waterman Ave.,  
St. Louis, Mo.



### MISSISSIPPI VALLEY MEDICAL SOCIETY 1939 ESSAY AWARD

The Mississippi Valley Medical Society offers a cash prize of \$100.00, a gold medal and a certificate of award for the best unpublished essay on a subject of interest and practical value to the general practitioner of medicine. Entrants must be members of the American Medical Association. The winner will be invited to present his contribution before the next annual meeting of the Mississippi Valley Medical Society at Burlington, Iowa, September 27, 28, 29, 1939, the Society reserving the exclusive right to first publish the essay in its official publication — the Mississippi Valley Medical Journal (Incorporating the Radiologic Review). All contributions MUST NOT exceed 5000 words, be typewritten in English in manuscript form, submitted in five copies, and must be received NOT later than May 1, 1939. Further details may be secured from Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209-224 W. C. U. Building, Quincy, Ill.

The 1938 winning essay, as well as several other essays which received meritorious consideration in the 1938 Essay Contest, appears in the Jan. 1939, issue of the Mississippi Valley Medical Journal (Quincy, Ill.).



## The Eight Point Program of The American Social Hygiene Association\*

WALTER CLARKE, M.D., New York City†

The American Social Hygiene Association's eight-point program in the current nation-wide fight against syphilis and gonorrhea will be extended during the coming winter on forty-eight state fronts. This program includes efforts to:

1. Increase the number of local citizen groups interested in educating the community concerning problems of social hygiene and to carry on needed work.

2. Tell the great masses of the people about these dangerous diseases and how they may be treated and cured.

3. Encourage good laws and their observance — laws preventing syphilis in marriage and childhood.

4. Attack commercialized prostitution and quackery — two arch-accomplices of syphilis and gonorrhea.

5. Aid employers and employees to strike at syphilis and gonorrhea in industry.

6. Answer many thousands of questions asked in letters and interviews by persons suffering from these diseases and in need of sympathetic and sound advice.

7. Assist parents, teachers, and church leaders in their effort to provide sound sex education and to offer practical preparation for marriage and parenthood.

8. Continue observations and informational service regarding official activities and programs and their results.

The American Social Hygiene Association functions through four divisions. These are Medical, Legal and Protective, Education, and Public Information and Extension.

Occupying the major attention of the Association at the present time are efforts to promote effective prenatal and premarital examination laws aimed at reducing syphilis in childhood and the family. The year 1939 is a legislative year in 44 states, a fact which suggests special opportunities for passage of sound and enforceable

laws while at the same time discouraging unsound and unnecessary legislation.

The Association operates with the cooperation of and through public health agencies, medical societies, and voluntary health and welfare organizations. Civic groups, women's clubs, churches, schools, youth bodies, etc., are enlisted in the program.

Since passage by the Congress last year of an amendment to Federal health laws, "to impose additional duties upon the United States Public Health Service in connection with the investigation of the venereal diseases", the Association has been interested in the effectiveness of this new measure. The LaFollette-Bulwinkle legislation provides for a current appropriation of \$3,000,000 to be allocated to the several states. These funds are to be matched by equal state appropriations and, significantly, the benefits are being extended to Puerto Rico, the Virgin Islands, as well as Alaska and the forty-eight states. In 1939-40, the appropriation will be for \$5,000,000 and the Association is especially concerned that the separate states should take necessary steps to avail themselves of these funds for strengthening their public health programs in the campaign against syphilis and gonorrhea.

Third National Social Hygiene Day which will be observed throughout the country on February 1, 1939, and which has as its slogan, "Guard Against Syphilis", will seek through some 5000 meetings to focus public attention upon current phases of the national and local programs. It is expected that this year, as in past years, public opinion will prevail in supporting efforts toward the attainment of new objectives in America's conquest of syphilis.

Connecticut, which was the first state to adopt a truly effective premarital examination law, has been praised by the Association for its pro-

(Continued on Page 50)

\*Presented at the Meeting of the Connecticut Public Health Association in Middletown, Connecticut, November 30, 1938.

†Executive Secretary, American Social Hygiene Association and Consultant on Syphilis, New York City Department of Health.

# State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

## The Pneumonia Service of the Bureau of Laboratories

FRIEND LEE MICKLE, Sc.D., and

EARLE K. BORMAN, M.S.\*

Hartford, Connecticut

The laboratory services of pneumonia that now are being offered to physicians on a 24-hour basis through the Bureau of Laboratories include the typing of specimens and the examination of blood cultures to determine bacteremias. Each physician practicing in Connecticut should have these laboratory services available in order to render the best service possible to his patients. Because similar services are becoming available to patients through physicians in an increasing number of cities and states throughout the United States, it is gratifying to know we again have them available in Connecticut during the present pneumonia season.

To the physician and to the patient it is important that determination of the type of pneumococcus be made whenever lobar pneumonia is present or whenever it is suspected. In a state as small in area as Connecticut, specimens can be examined in the central state laboratory whenever local laboratory facilities are not more quickly available. Through the use of Federal funds the necessary supplies, materials and test animals have been secured and two bacteriologists have been added to the staff of the Bureau of Laboratories for the period from December 1, 1938 through March 31, 1939 and one of these bacteriologists will be retained on the staff until June 30, 1939. This should supply the laboratory personnel necessary during the present pneumonia season and will allow for the continuation of the work on a 24-hour basis until the end of March. Funds have been requested in the Department's regular budget to place this work on a permanent basis beginning July 1, 1939.

### Growth of Laboratory Service

It should be of interest to recall that in 1917 the Bureau of Laboratories offered its first pneumococcus typing service to physicians. That service was limited to mouse inoculation tests for pneumococci of Types 1, 2 and 3. The Sabin test was added in 1932 to hasten the reporting of results. The Neufeld "Quelling" test was introduced in January, 1933 and was extended on January 1, 1935 to include the 32 types. In connection with the general curtailment of laboratory work that the Public Health Council found was necessary to maintain the cost of our laboratory work within the budget and to bring the overtime work of the staff within reasonable bounds, all pneumococcus typing services other than the Neufeld test for the types for which therapeutic serum was being supplied by this Department were dropped, on July 1, 1937. That has limited typings during the summer months to Types 1, 2, 3, 4, 5, 7 and 8. The policy is still in force except for the period during which the special pneumonia funds are available from government sources. It is hoped that this situation will be adequately taken care of in the budget which will be acted upon by the 1939 General Assembly.

### How to Use the 24-Hour Service

All physicians have recently been notified by a circular letter that until March 31, 1939 a worker to care for typings and blood cultures will be at the Laboratories until midnight every day of the week including holidays. After midnight "on call" services will be available in emergencies. Specimens for typing will be examined

\*Director and Assistant Director, Bureau of Laboratories, State Department of Health, Hartford, Conn.



immediately upon receipt. The Neufeld test for Types 1 to 32 will be made directly whenever a suitable specimen of sputum is received. Mouse inoculations and blood-agar plate cultures will be used to supplement and confirm all findings by the direct Neufeld typing. Reports will be made by telephone as promptly as examinations are completed and a written report will follow promptly for the physician's file.

Specimens should be sent to the Laboratories by special messenger whenever possible. A member of the patient's family often may be found available for this purpose. Specimens should be brought to the Bureau of Laboratories, 1179 Main Street, Hartford. Out-of-hour specimens should be taken to the fourth floor at the far end of the corridor. If the outside door to the building should happen to be locked, the messenger should go to the nearest phone, call 7-6341, and ask "Pneumonia Service" to have the door opened.

Containers for the collection of specimens may be obtained from the Bureau of Laboratories or from local health officers. When these are not available, any clean dry container of adequate size, such as a small jar, a cup, glass tumbler or even a pasteboard or paper container may be used for sputum. Suitable outfits containing culture medium for blood cultures are available at the Bureau of Laboratories upon request.

#### **Suitable Specimens**

In pneumonia particular attention should be paid by the physician to obtaining a suitable sputum. A fresh sample from the lower respiratory tract is ordinarily obtainable during the time the physician devotes to physical examination unless the patient is a very young child. Repeated urging, turning the patient on his side, measures to relieve pleural pain or moistening the patient's throat and mouth may be found necessary in some cases.

Throat swabs are not so satisfactory as sputum since typing may be considerably delayed due to the necessity for culture. If sputum is not obtainable, swabbings should be collected on three or four swabs by inserting them into the pharynx preferably while the patient is coughing, taking especial care to touch the mucosa only in the pharynx. Deeper penetration by use of a laryngoscope may be advisable.

Blood cultures are of importance in determining the necessity for more intensive serum treat-

ment. It is advisable to take these cultures when the sputum for typing is obtained and again after the usual course of serum therapy. A positive blood culture is valuable confirmatory evidence of the infecting type of pneumococcus and is an important prognostic aid.

#### **The Use of Antipneumococcus Serum**

In a letter recently sent to physicians, the Director of the Bureau of Preventable Diseases of the State Department of Health emphasized the following points regarding the use of antipneumococcus serum:

1. The early administration of type-specific antipneumococcus serum gives the best results. Serum should be given within the first twenty-four hours after onset whenever possible. After the first twenty-four hours, or forty-eight hours at most, its salutary effect is rapidly lost.

2. Serum should not be given until the pneumococcus causing the pneumonia is typed so as to give type-specific serum. **SEND SPUTUM TO THE LABORATORY BY SPECIAL MESSENGER.** The state laboratory now has a twenty-four hour service. A number of local laboratories in health departments and hospitals also give the same service.

3. A receipt is required by the local health officer or his agent for each lot of serum given out.

4. In order to avoid delay, serum may be obtained from the local health officer for patients able to pay and payment may be made to the local health officer. (Checks should be made payable to the Connecticut State Department of Health).

5. A pneumonia case record form will be found in each package of antipneumococcus serum distributed by the state. This record should be made out giving complete details and delivered to your local health officer for transmittal to the state department of health. It is highly important that this information be made available as evidence that investment in serum is worth while as a life saving measure.

6. Antipneumococcus serum for Types I, II, III, IV, V, VII and VIII will be distributed this year as last. If more funds were available, serum for additional types could be furnished.

7. Twenty cities strategically located have been selected as distributing centers for antipneumococcus serum. In the cities of Bridgeport, Hartford, New Britain, New Haven and Waterbury, distribution is made direct from the health department. In the cities of Bristol, Danbury, Derby, Manchester, Meriden, Middletown, New London, Norwalk, Norwich, Putnam, Rockville, Stafford Springs, Stamford, Torrington and Willimantic, the local hospital had been selected by the health officer as the distributing center. Information concerning any change in this plan can be obtained from the health officer of the city concerned. Physicians from near-by towns can obtain antipneumococcus serum from a distributing center nearby.

(Continued on Page 50)



*NEW YEAR'S GREETINGS*  
*from the*  
*PRESIDENT*

To us as individuals, new years and birthdays have a different significance than to such an organization as the Connecticut State Medical Association. Those who saw the inception of this society have long since passed to their reward. With their increasing years came senility and its accompanying feebleness. On the contrary to this association as the years have passed has come increasing virility and strength. The Connecticut State Medical Society has striven to keep pace with the constant changing trends in scientific and economic medicine. In the past year, we have given ear to many and varied discussions on prepayment hospital plans and in the past few months to suggestions having to do with a better method of meeting costs of medical care. Whatever may be our personal opinions on these subjects the information we have obtained from speaker and printed page should make for us a more intelligent attitude of mind and so better fit us to meet the obligations we have assumed as physicians.

A large measure of satisfaction should be ours that various departments of the State Government have sought our advice and counsel in matters pertaining to public health and medical service. May we continue to deserve this recognition.

While it is not amiss to desire for the year 1939 a competence over and above that of previous years may our chief concern be for a greater development of those qualities which makes us better and more understanding physicians.

HUGH B. CAMPBELL,  
President, State Connecticut Medical Society.

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**MANUSCRIPTS.**— Manuscripts should be type-written, double-spaced, on white paper  $8\frac{1}{2} \times 11$  inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

**ILLUSTRATIONS** — Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

**NEWS.**— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

**ADVERTISEMENTS.**— All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

**SUBSCRIPTIONS.**— Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

**REPRINTS.**— Reprints of papers and obituaries may be obtained from the Editor at cost.

## • Editorials •

### THE NEW YEAR

Encouraged and heartened by the many kind expressions of appreciation and by the willing cooperation afforded him by the readers of the Journal, the Editor finds it a real joy to extend New Year's Greetings to our many readers in Connecticut, in the United States and in far distant countries. As the official publication of the Connecticut State Medical Society we are justly proud of the Society's progress during 1938. It has taken an active part in the establishment of prepaid hospital service plans, it has engaged in a study of the needs of cancer patients in the State, it has established a Committee on Public Relations, another on Industrial Health, another to study the Medical Practice Act and a Committee to Study Employment in State Institutions. At every point the Society has shown progress, an interest in the individual problems of its members and a desire to serve the public welfare.

In 1942 our Society will be 150 years old, and what could be more fitting than to gather in the town of its origin to pay homage to our early leaders? While we may review recent achievements with a certain satisfaction, we must not let it obscure the danger signals ahead. The New Year approaches with greater uncertainty than any of its predecessors, nevertheless, we face the problems of another year with anticipation and courage.

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### SCARLET FEVER IMMUNIZATION

The Dick test has been shown to be a reliable index as to the amount of immunity which an individual has to scarlet fever. The effectiveness of the toxin as an immunizing agent has been established. The literature contains a record of over 20,000 susceptible persons who have been actively immunized against this disease with only one subsequent case of scarlet fever. These persons have been under observation for a length of time varying from a few months to over ten years. The procedure has been effective in controlling outbreaks in institutions and in protect-

ing individuals. Immunity develops rapidly and the Dick test becomes negative in a large percentage of cases.

Many of the persons immunized develop minor local reactions and from ten to fifteen per cent have constitutional symptoms of varying degrees of severity. Such reactions soon subside and no record has been found of any residual harmful effects. Although not proven, evidence suggests that active immunity protects from invasion by the bacteria as well as from the effects of the toxin.

Active immunization for the control of scarlet fever has not been accepted widely. The principal objections have been the number of doses required and the severity of the reactions. The reactions have not been serious enough to contra-indicate the procedure, and active immunization is now recognized as an effective means of scarlet fever control. It usually protects the individual from what may be a long and expensive illness with possible complications. This preventive measure should be explained to parents, and they should make their own decision as to whether to accept immunization against scarlet fever for their children.

B.G.H.



#### POST-GRADUATE MEDICAL EDUCATION AT YALE

By the efforts of the Federal Government in placing funds available through the Social Security Act many States during the past two years have enjoyed the so-called refresher courses in obstetrics and pediatrics. Without doubt these courses have accomplished some useful purpose, although in Connecticut their value may be questioned. Medicine has made rapid strides in the past decade. Many physicians, with little or no time for study, have found themselves with difficulty endeavoring to build up their own diagnostic acumen and therapeutic armamentarium to keep pace with these developments. Post-graduate education has entered the field through necessity rather than by invitation. Clinical congresses, post-graduate institutes, opportunities for clinical study in medical centers have multiplied almost over night.

Elsewhere in this issue of the Journal will be found an announcement of a course in obstetrics and gynecology to be given at Yale University School of Medicine during February and March.

It is superfluous to remind our members that Connecticut has but one medical teaching center and, whether or not we received our degree in medicine from it we owe a certain allegiance to this School. Yale University School of Medicine has shown our State Society the heartiest cooperation in all the latter's educational activities. This institution is endeavoring to serve us in every way possible.

The Course in obstetrics and gynecology planned for this winter aims to stress the practical points in these fields for the use of the general practitioner. The conferences will be informal and will afford those who attend an opportunity to discuss their own particular problems. We lend our hearty endorsement to this program and feel confident that many will avail themselves of this exceptional opportunity.



#### DEATH AND DEPRESSION

When the economic depression descended on the country nearly a decade ago it was expected by many and forecast by some that the health of the people would be adversely affected by unemployment and other unfavorable conditions which would lower the standards of living. That this quite logical opinion has not proven correct is graphically shown by the comparative mortality rates recently published by the Public Health Service. In 1928, the last pre-depression year, the death rate was 12.1 per 1000 of estimated population. Since that time there has been an almost continuous decline in the rate. In 1929 it was 11.9; in 1930, 11.3. This figure has been exceeded only once in the ten years, when in 1936 it rose to 11.5. The year 1933 brought the low point in the economic curve, and in that same year the lowest death rate, 10.7, ever recorded in this country was experienced. It now appears that 1938 will equal or lower the record made in 1933.

A clear explanation of this pleasantly surprising state of affairs cannot be made, for there are so many contributing factors involved. However, it is interesting to speculate on the influences that brought it about. First, the absence of any serious and widespread epidemics surely had an effect and the cumulative results of already established public health measures probably played no small part. With a falling off in employment there was inevitably a reduction in the fatalities arising in industry. Less tangible



than any of these, but perhaps the most potent factor of all, was the increased effort by one means or another, to give medical care to the lower economic and destitute groups of people.

It is not always altogether correct to infer that a decreased mortality is accompanied by an equal falling off in the sickness rate, but there is certain justification for an opinion that there has been some decrease in the total of sickness and that the health of the nation has not suffered badly during the trying years of the depression.

C.B.

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### SEX INSTRUCTION IN THE SCHOOLS

"Because it is peculiarly within our province to know the great potentialities of sex both for evil and for good, we physicians must accept the responsibilities of seeing to it that no irreparable damage is done by inadequate or misguided teaching; we must, of necessity, take the initiative in surrounding the movement for sex education with all of the safeguards that scientific thought can provide. True it is that sex education, successfully carried out, would pay society for its cost, however great that be. In the reduction of venereal diseases alone, the returns would be immeasurable. But such education, rashly or poorly attempted, would be costly to society even though it were achieved without any increase in our educational budget. Our not inconsiderable influence in our respective communities must be brought to the support of those who are working for a program of social hygiene in the \* \* \* schools, but we must be insistent upon the observance of precautions to keep the program on a safe, sane footing."

—*Del. State Med. Jour.*, Oct., 1938.

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### DOCTORS AND THEIR SONS

The above is the title of an excellent editorial appearing in the November issue of *Medical Annals of the District of Columbia*. Whether or not one agrees with all that the Washington editor says, his premises are food for thought and very serious thought by those of the profession who may have sons looking forward to carrying on in their fathers' footsteps.

We quote a few lines: "There is no need to be unduly concerned about changes in medical practice so long as physicians meet the issues

which arise, honestly and with courage. The voice of a great profession will not be disregarded by the people where health is concerned." (But the voice of the people has been a bit drowned out of recent years. Ed.) \* \* \* "Surely pessimism about the future is unwarranted. In fact, we feel that such an attitude does not reflect credit on the medical profession.

"As to opportunities, no one doubts that they will be greater than ever. Scientific medicine has taken great strides forward. Much has been learned, but there still remains a vast field to be investigated. Preventive medicine is practically in its infancy and its general application will open a wider field for the practitioner of the future. Under these conditions there will be greater need for more and better equipped physicians. \* \* \*"

"So we say to the doctor: If your son has a genuine feeling for medicine, encourage him. There always have been and always will be opportunities in medicine."

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### FEDERALIZED MEDICINE

"The two main problems up for consideration, namely, the medical care of the indigent sick and the medical care of those in the low income brackets, are eternally becoming confused with each other, and with the medical care of those living beyond their means and the medical care of those prejudiced against payment for medical care of any kind. If medical care is so essential to the welfare of human beings there should be no objections on the part of the recipients paying for it even though sacrifices need to be made in other directions, but unfortunately there are.

"The broad comprehensive plans thrown into the recommendations advanced in Washington call for a greater medical personnel than could be created in ten years if there were no mortality among the doctors. Obviously medical work would have to be assigned to non-medical personnel. This would result in a breakdown of medical efficiency.

"The warning to go slow is imperative. Meanwhile a little more education and information would not hurt the lay workers now so enthusiastic for medical changes."—*Wkly Roster & Med. Dig.*, Oct. 8, 1938.

# From the Secretary's Office

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## THE PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION TO BE THE GUEST OF THE SOCIETY

The Society is especially fortunate to have Dr. Irvin Abell, the President of the American Medical Association, for a guest at a mid-winter dinner meeting on January 21st. Dr. Abell will speak on social-medical developments in the Nation. Every member of the Society should plan to attend. Will you make your reservations promptly?

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## COMMITTEE ON INDUSTRIAL HEALTH HOLDS FIRST MEETING

The newly formed Committee on Industrial Health under the Chairmanship of Dr. Clifford Kuh of New Haven held its first meeting on November 29th. The members of the Committee were dinner guests of Dr. Cole Gibson, Superintendent of Undercliff Sanitarium, Meriden. Dr. Kuh, Dr. Paul Vestal, Dr. Joseph Linde, Dr. W. E. Carroll, Dr. Gibson, Dr. Donald Wells, Dr. Benedict Whipple, Dr. W. A. Sunderland, and Society's Secretary were present. Various projects were presented and the Chairman's report will be of interest.

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## REFRESHER COURSE IN OBSTETRICS AND GYNECOLOGY

This office has for some time been interested in the project of the Department of Obstetrics and Gynecology of the Yale School of Medicine to offer a course in Obstetrics and Gynecology for general practitioners in Connecticut. The course, the announcement of which will be found elsewhere in this issue, will be given during February and March. It is another evidence of the important contribution to Connecticut medicine made by Yale.

## COMMITTEE TO STUDY MEDICAL PERSONNEL IN STATE INSTITUTIONS

As announced last month the Society has been asked by the Personnel Director of the State to appoint a Committee to study the conditions of employment of physicians in our State institutions and to make suggestions as to how the State service might be made more attractive. The Chairman of the Council has asked Dr. Stanhope Bayne-Jones, Dean of the Yale School of Medicine to serve as Chairman of this Committee, Dr. David R. Lyman, Director of the Gaylord Farm Sanitarium and Dr. Wilmar M. Allen, Medical Director of the Hartford Hospital. The preliminary plans for the study have been made and it is expected that the report will be ready in April.

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## FOLDER ON ADOPTION

The Children's Bureau at Washington has just published a fifteen page illustrated leaflet on "Adoption — What It Means". This was prepared in response to requests for popular material appropriate to be given to parents wishing to adopt a child and to others interested in questions involved in the adoption of children. Several questions pertinent to the subject are discussed.—*The Child*, Oct. 1938.

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## COMMITTEE ON CLINICAL CONGRESS

The General Committee of the Clinical Congress under the chairmanship of Dr. Bayne-Jones had its meeting on December 3. There were thirty-four present including Dr. Westcott and Dr. Wing of Providence, Rhode Island. Proposals for the program for the 1939 Congress were made and once more this interesting and important activity of the Society is under way.

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## SECTION ON Orthopedic Surgery

### State Program for Crippled Children

The December issue of the Journal contains a summary of the Connecticut State program for crippled children under the guidance of Russell V. Fuldner, M.D. Six children's clinics held monthly have seen a total of 479 patients. Although the patients have come from all over the state, certain areas have not contributed to the success of these clinics as much as they probably will in the future.

There have been 105 patients admitted to hospitals for care with most of the others under treatment in the clinics. According to this report there were only 37 patients who offered a poor or hopeless prognosis. This report should evoke considerable interest. It must be kept in mind, however, that it represents only nine months of the first year's operation.

In comparing this report with a similar report edited by the Washington State Program for Crippled Children, which has been operating for a total of two years, there are a number of interesting differences. This report lists 1,940 children as having attended the clinics during the two years. Their clinics are held at intervals of six months in six different centers. The Washington program, furthermore, has selected seven orthopedists to serve as a committee to review cases referred to the Crippled Children's Program. This committee assigns the children for treatment to orthopedic staff surgeons in hospital centers near the children's homes. In their program is also included the State Department of Vocational Rehabilitation where the young adults are trained and placed in employment.

### Death of Sir Colin MacKenzie, Australia

As an orthopedist of unusual capability, Sir Colin first propounded in 1904 the theory of muscle re-education in post-poliomyelitis cases. This led to the publication of his remarkable book, "The Action of Muscles Including Muscle

Rest and Muscle Re-education". This volume should repose in the ready reference file of every orthopedist. As a comparative anatomist he investigated and developed the Australian Fauna, eventually presenting his collection to the Australian government. This collection was housed in a museum built by the government with Sir Colin as its director. He was serving in this capacity when death overtook him.

### Experimental Transmission of Poliomyelitis to Cattle

The Swiss Medical Journal of October 8, 1938, reports the successful transmission of poliomyelitis material from human subjects to three heifers. These three animals developed what appeared to be a true flaccid paralysis of extremities. Subsequently, muscle atrophy was noted in at least one case. Microscopic reports have not been made to date to prove the existence of a pathological process identical with that of anterior poliomyelitis in the human. Further investigations are being carried out.

### Section Meets

The Chairman, M. K. Lindsay, M.D., presiding, conducted a short meeting in New Haven December 1 at which resolutions were introduced and passed. A representative number were present.

### Orthopedic Forum

Dr. Edwin Pyle of Waterbury entertained the Orthopedic Forum, a representative group of orthopedists from various parts of the country, at a luncheon and a discussion program in Waterbury on December third. Drs. Denis O'Connor, Edwin Pyle, C. W. Goff and R. M. Yergason presented cases and papers.

### Dr. Gilbert E. Haggart

The Hartford Medical Society entertained Dr. Haggart of Boston on December fifth. Dr. Haggart read a paper on "The Diagnosis and Treatment of Low Back Pain and Sciatica". His use of procaine as a diagnostic aid as well as a therapeutic agent calls our attention again to this very useful procedure.

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## AN ACT GOVERNING HOSPITAL SERVICE CORPORATIONS\*

### Definition

A hospital service corporation is defined as a non-profit sharing corporation without capital stock organized under the laws of the State for the purpose of establishing, maintaining and operating a plan, whereby hospital care may be provided, at the expense of said corporation, by a hospital to subscribers to said plan under contract entitling such subscribers to certain hospital service. Every such corporation shall be governed by this Act and shall be exempt from provisions of the insurance law of the State unless specifically designated herein.

On or before the first of July 1939, and annually thereafter in the month of July, The Connecticut Medical Examining Board and the Connecticut Homeopathic Medical Examining Board, acting as a joint board, shall submit to the Health Commissioner of the State of Connecticut a list of approved hospitals within the State of Connecticut, and such list after being filed with the Commissioner of Health shall become a list of approved hospitals for the purposes of this act.

### Incorporation

Persons desiring to form a hospital service corporation may incorporate under the general law of the State governing corporations, but subject to the following provisions:

1. The certificate of incorporation of each such corporation shall have endorsed thereon or attached thereto the consent of the Commissioner of Insurance, if he finds the same to be in accordance with this Act.

2. Said Certificate shall include a statement of the territory in which the corporation will operate, the services to be rendered by the corporation and the rates currently to be charged therefor. Further, said certificate shall be accompanied by two copies of the contract for services which the corporation proposes to make with subscribers and two copies of the type of contract which said corporation proposes to make with member hospitals.

### Form of Contract

No contract between any such corporation and subscribers shall entitle more than one person to services except that such contract may be issued for service to subscriber and wife or to subscriber and husband or to subscriber and family, or to subscriber and dependent or dependents related by blood, marriage or adoption or to subscriber and ward. Such contract with subscriber shall be in writing and a copy thereof furnished to each subscriber. Further, such contract shall contain the following provisions:

1. A statement of the amount payable to the corporation by the subscriber and the manner in which such amount is payable.

2. A statement of the nature of the services to be furnished and the period during which they will be furnished, and if there are any services to be excepted a detailed statement of such exceptions.

3. A statement of terms and conditions upon which the contract may be cancelled or otherwise terminated at the option of either party.

4. A statement that the contract includes the endorsement thereon and attached papers, if any, and contains the entire contract.

5. A statement that no statement by the subscriber in his application for a contract shall void the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract.

6. A statement of the period of grace which will be allowed the subscriber for making any payment due under the contract. Such period shall not be less than ten days.

### Rates and Contracts to be Approved

No such corporation shall enter into any contract with subscribers unless and until it shall have filed with the Insurance Commissioner of the State a full schedule of the rates to be paid by the subscribers and shall have obtained the said Commissioner's approval thereof. The Commissioner may refuse such approval if he finds such rates are excessive, inadequate or discriminatory.

No hospital service corporation shall enter into any contract with subscribers unless and until it shall have filed with the Insurance Commissioner of the State a copy of such contract, including all riders and endorsements thereof and until the said Commissioner's approval thereof shall have been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation either of his approval or disapproval thereof.

### Reports and Examinations

Every such corporation shall annually, on or before the first day of March, file in the Office of the Insurance Commissioner of the State a statement, verified by at least two of its principal officers, showing its condition on the 31st day of December then next preceding, which shall be in such form and contain such matters as said Commissioner shall prescribe.

Examination of the financial condition of each such corporation by the Insurance Commissioner or his representatives shall be made annually. The Commissioner of Insurance, or any deputy or examiner or any other person whom he shall appoint, shall have the power of visitation and examination into the affairs of any such corporation and free access to all of the books, papers and documents that relate to the business of the corporation, and may summon and qualify witnesses under oath to examine its officers, agents or employees or other persons in relation to the affairs, transactions and condition of the corporation.

All costs of acquisition and of management activities shall be under the supervision of the Insurance Commissioner.

### Investments

No such corporation shall invest in any security other than those permitted by the law of the State for trust funds, except real estate mortgages.

### Liquidation or Merger

Every such corporation shall be subject to liquidation, dissolution or rehabilitation and such proceeding

\*Final draft of bill that will be introduced into the forthcoming General Assembly by the Governor's Conference Committee, an enabling act for the operation of prepaid hospital service plans.

shall be under the supervision of the Commissioner of Insurance who shall have such powers hereunder as he possesses in reference to domestic insurance corporations.

Any hospital service corporation may merge with any other hospital service corporation or corporations subject to the approval of the Insurance Commissioner.

#### **Workmen's Compensation Law Not Affected**

No provision of this Act or any contract for hospital service by such corporation shall, in any way, affect the operation of Workmen's Compensation laws of the State.

#### **Existing Hospital Service Corporations**

Hospital service corporations heretofore formed under the general law of the State are hereby ratified and approved, subject, however, to all provisions of this Act, including the right of the Insurance Commissioner, upon examination thereof, to proceed in the matter of liquidation, dissolution or rehabilitation.

#### **Fraternal Benefit Societies, etc.**

Fraternal Benefit Societies and life and/or accident insurance companies are not affected by this Act.

#### **Appeal**

From any order or decision of the Insurance Commissioner, an appeal may be taken by any person or corporation aggrieved thereby to the Superior Court for the County of Hartford on the first Tuesday of any of the next three months following such order or decision.

In case any dispute arises between a subscriber and a hospital plan corporation or between a member hospital and the hospital plan corporation, or between two or more hospital plan corporations, the same shall be referred, at the request of any party to such dispute, to the Insurance Commissioner who shall have the power to hear and decide same, subject to the provision for appeal to the Superior Court as above provided.

#### **Exemption from Taxation**

All property of any such corporation is hereby declared exempt from State, County, District and municipal taxes.



### **THE SYPHILIS CAMPAIGN**

"Behind the Syphilis Campaign", a pamphlet compiled by Dr. Philip S. Broughton with the aid of members of the Division of Venereal Diseases of the United States Public Health Service, has just been issued by the Public Affairs Committee of New York City. It carries a message to the lay public about syphilis and within its covers the author briefly describes the symptoms of syphilis and the methods of spread.

Each year 518,000 cases of newly infected patients report to doctors and clinics for treatment and, in addition, 598,000 advanced cases come to doctors for the first time. The advanced

cases are important because they had a year or more during which they were uncontrolled and able to spread the disease. Nearly half of these infections are innocently acquired: in marriage, at birth, through chance contacts, or, rarely, through soiled towels, drinking cups and similar articles. The author points out that were the syphilis rate in the United States as low as it is in Denmark, we would have 26,000 cases instead of more than 1,000,000.

The cost of this disease is stupendous and is summed up in a slogan of the United States Public Health Service: "The cheapest thing America can do with its million cases of syphilis is to cure them."

The modern approach in the current campaign to eradicate syphilis has, as its keynote, the appeal to confidence and not to fear, because a frightened patient is likely to take the wrong course and a quack may quiet his fears more quickly than an honest physician. Specifically, the present campaign directs itself to the creation of adequate facilities for diagnosis and treatment, routine blood tests and the follow-up of cases.

The author stresses the fact that syphilis can be cured and that early treatment shows the best results. Even in late stages, however, treatment markedly diminishes the frequency of brain and nervous system involvement. In an untreated syphilitic mother there are five chances out of six that the baby will be born dead or infected with syphilis, whereas, in the cases of the treated mother, the baby will be healthy ten times out of eleven.

The United States Public Health Service has formulated a policy for industry in its relation to syphilis. In brief this policy encourages the following: (1) Routine blood tests for job seekers with employment if syphilitic, providing treatment is accepted. (2) Blood tests as part of regular physical examinations of employees. (3) Educational program which will give employees an understanding of the problem. (4) Treatment of employees by industrial medical services, unless competent treatment can be arranged through private physicians.

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# Our Neighbors

## MASSACHUSETTS

With a registration of almost 900 the result of the New England Post-graduate Assembly held in Cambridge recently was a distinct success. The Committee on Post-graduate Instruction of the Massachusetts Medical Society deserve the highest praise for this initial endeavor.

An analysis of all puerperal deaths in Massachusetts during 1937 has just been completed by the Massachusetts Medical Society and the Department of Public Health. One of the outstanding conclusions reached was that many of these women received insufficient or inadequate antepartum care, especially in the toxemia and cardiac groups. Sepsis took a heavy toll with attempts to induce abortion a leading factor. The realization of the need for early hospitalization and the more frequent use of blood transfusion was emphasized. This study is to continue for four more years.

Massachusetts in 1937 had 62,228 live births and 1760 still-births, a total of 63,988 births, according to Dr. Robert L. DeNormandie. As a result of questionnaires sent out it was found that there were 2082 cesarians and 24 hysterotomies, a total of 2106 abdominal deliveries, or an incidence of 1 in 30.3 births. In this entire group there were 66 maternal deaths, a mortality rate of 3.1 per cent. Sepsis accounted for almost one-half of this number.

Harvard University Medical School has awarded 63 scholarships totaling \$25,578 to medical students and has also awarded 24 fellowships totaling \$21,650 for the coming academic year.



## NEW YORK

Dr. Walter C. Alvarez of Mayo Clinic will be a guest speaker at a meeting of the Westchester Society of Gastroenterology at New York Hospital, Westchester Division, in White Plains on the evening of January 10. His subject will be "The Treatment of Indigestion."

## RHODE ISLAND

"The Hurricane - From a Nurse's Diary" appearing in the October issue of the Rhode Island Medical Journal affords an excellent and vivid first hand picture of some of the experiences encountered during that outburst of the elements on September 21. Doubtless there are many of the profession in New York and New England who could give us tales of suffering and disaster on that and succeeding days which would seem almost unbelievable.

The reunion of former interns of the Rhode Island Hospital was held on September 9 and 10, 1938. One afternoon was given over to papers presented by visiting former interns. On this program Dr. Arthur H. Morse, Professor of Obstetrics at Yale, discussed "Pathology and Treatment of Ante Partum Hemorrhage".

## - NEWS -

### *from County Associations*

## Hartford

Dr. Gladys Smithwick, formerly resident anesthetist at the Hartford Hospital, recently read a paper on "Pentothal Sodium for Intravenous Anesthesia" before the Frankfort Medical Society, Kentucky.

In the Journal of the A. M. A. for November 12, 1938, under Clinical Notes, appears an article on "The Blood Sugar and Cardiac Involvement in Rheumatic Fever" by Dr. Peter J. Steincrohn of Hartford.

The names of two former interns of the Hartford Hospital appeared in the November issue of the Journal of the Michigan State Medical Society. Dr. Harry J. Burkholder of Alpena, Michigan, who completed his hospital work in Hartford in 1917, is one of the authors of "Ten Years of Treatment and Progress in a Case of Myeloid Leukemia". Dr. Clarence D. Hart of Newberry, Michigan, a more recent dweller in our midst, has been honored by the election to the councilorship of the twelfth district of the Michigan State Medical Society.



### Litchfield

In memory of Uri T. Hungerford, doner of the Charlotte Hungerford Hospital, the sixteenth annual hospital dinner was given by the corporators and medical staff on December 12th at the Conley Inn in Torrington. John A. Coe, president of the American Brass Company, served as toastmaster. F. L. Braman, president of the board of governors, ennumerated certain financial problems which this hospital is facing. He stated that the cost of patients care in this hospital was distributed in each dollar expended as follows: 63 cents from patient, 34 cents from endowment income and 3 cents from state funds. Under consideration is a bill to compel hospitals receiving state grants to accept city cases as well as state cases at eight dollars a week. He stated that the passage of this bill would place an additional burden on the hospital.

Guest speaker was Dr. Wilmar M. Allen of Hartford. Dr. Allen described the functions of a modern hospital and emphasized that these functions included care of the sick, teaching and research.

Director Albert W. Buck outlined briefly the growth and development of the hospitalization insurance plan which will begin operation in this hospital in January 1939.



### Middlesex

Among the changes in the Revised By-Laws of the Middlesex County Medical Association which were adopted at the October meeting is one pertaining to the formation of an executive committee. This committee will consist of the president, vice president, clerk and two elected members. Its duties have been outlined and consist in arranging for regular and special meetings, preparing the programs, selecting delegates to the other county associations, recommending at the annual meeting the amount needed for the annual dues and reporting to the councilor any member who, in their opinion, should have his dues paid from the O. C. Smith Fund. This committee is authorized to act for the association when it is not in session and is expected to make a report of its activities at each regular meeting for ratification or otherwise. The duties of the pre-existing committee on Public Policy and Legislation have been taken over by this committee.

These changes are expected to result in a smoother and more efficient functioning of the association.

Announcement was made on November 3 of the appointment of Mr. Howard S. Pfirman as superintendent of the Middlesex Hospital in Middletown. Mr. Pfirman who has been assistant superintendent of the Prospect Heights Hospital in Brooklyn, N. Y., succeeds Miss Frances P. West who resigned in June. The new official is a graduate of Columbia University and has taken considerable post-graduate study at several metropolitan institutions. He assumed his new duties on Dec. 1, 1938.

At a recent survey at the Middlesex Hospital a proposal was advanced that active medical men no longer serve on the Boards of Corporation or Directors of the Hospital.

Acting on this suggestion the Board of Corporators accepted the resignation of the medical men serving on the board. These physicians who also withdrew from the Board of Directors were Dr. James Murphy, Dr. F. B. Bradeen, Dr. G. M. Craig, Dr. Jessie W. Fisher, Dr. Alfred N. Sweet and Dr. Carl C. Harvey. Each was made a corporator and director emeritus. Four new corporators were elected. They were Gordon D. Bevin of East Hampton, Louis A. Knox and Mrs. W. W. Wilcox, Jr., both of Middletown, and Daniel H. B. Starr of Portland.

Dr. Carl C. Chase of Middletown, a member of the staff of the Middlesex Hospital, has been notified of his certification by the American Board of Ophthalmology.

Dr. Joseph Beauchemin, a member of the staff of the Connecticut State Hospital, addressed the Central Medical Society, November 14. His subject was "General Considerations on Allergy and Desensitization."

A banquet was given at the Connecticut State Hospital recently to the trustees, members of the medical staff and guests to recall memories of former days. The event was prompted by the scheduled demolition of the old main building, first of the hospital which was built in 1867.

Long Lane Farm, a state owned correction school for girls, is in the midst of a construction program. Some of the old buildings which were put up when the school was first opened in 1870 are being torn down. In their place will be built a new administration building, a new cottage and a new schoolhouse.

# Opportunities Available for Physicians of Connecticut

in the Yale University School of Medicine and Affiliated Institutions

Any physician of good standing in the community may, on application to the head of a department in the Yale University School of Medicine, obtain permission to attend clinics, lectures, conferences, or ward rounds; or to do special work in association with the laboratories connected with the various departments. Some opportunities are listed below:

## CLINICAL

Ward rounds in the New Haven Hospital, clinics, and conferences are held by the clinical departments as follows:

**MEDICINE:** rounds daily at 10:00 A.M. on each of the three wards and in the Metabolic Section; clinic Thursdays at 12:00 M.

**SURGERY:** General Surgery program. Wednesdays: case conferences 9:00 to 10:15 A.M.; clinic 12:00 M. to 1:00 P.M.; X-ray conferences for topics of diagnosis and therapy 4:00 to 5:00 P.M.; Tumor Clinic conferences Tuesdays at 2:00 P.M.; Ophthalmology conference with Department of Pathology second and fourth Thursdays at 4:00 P.M.; Orthopedic conference with Section of Radiology daily at 11:00 A.M.; Orthopedic Seminar, Tuesdays at 8:00 P.M.; Otolaryngology: clinical presentation of unusual cases at 11:00 A.M. Wednesdays, Otolaryngological clinic; Urological Section program Mondays: grand rounds at 8:30 A.M.; conferences with Section of Radiology at 9:30 A.M. and, on alternate Mondays, a pathological conference at 10:30 A.M.; Urological Surgery, Tuesdays and Fridays beginning at 8:30 A.M.

**PEDIATRICS:** Ward rounds daily by the junior staff at 9:00 A.M., and by the senior staff at 11:00 A.M.; clinic, Mondays at 12:00 M.; on Wednesdays at 12:00 M., from October to May, conferences for staff and other physicians at which cases and problems are discussed.

**OBSTETRICS AND GYNECOLOGY:** Ward daily at 9:00 A.M.; conference clinic Tuesdays, at 12:00 M.

Post-graduate course of 6 conferences on clinical problems every Friday from February 17 to March 24, from 3:00 to 5:00 P.M. at the New Haven Hospital. Applicants should apply to Department of Obstetrics and Gynecology before February 1. Fee: \$10.

**PSYCHIATRY:** Staff conferences Mondays at 4:00 P.M., Wednesdays and Fridays at 9:00 A.M., clinic, Fridays at 12:00 M.

**PATHOLOGY:** Conferences Clinical Medicine:—Pathology Mondays and Fridays at 4:30 P.M., Surgical Pathology Wednesdays at 11:00 A.M., Ophthalmology-Pathology second and fourth Thursdays at 4:00 P.M.

Informal post-graduate course in Neuropathology, alternate Wednesdays at 4:00 P.M., November 2 to May 31 (16 meetings).

**PUBLIC HEALTH:** Seminars Tuesdays and Fridays at 5:00 P.M.

The requirements for the degrees of Master of Public Health (M.P.H.) and Doctor of Public Health (Dr.P.H.) are described in the catalogue of the School of Medicine.

**THE CLINIC OF CHILD DEVELOPMENT:** A series of lectures and demonstrations (Pediatrics 120) dealing with mental growth and developmental diagnosis Wednesdays at 4:30 P.M. Observation in the Guidance Nursery by appointment.

**WILLIAM WIRT WINCHESTER HOSPITAL:** Ward rounds Wednesdays and Fridays, 9:00 A.M. to 12:00 M.; case conferences Fridays, 11:15 A.M. to 12:30 P.M.

**LECTURES:** Class lectures for medical students, as well as the other class exercises, are open to all interested.

## PRECLINICAL

**LECTURES.** Classroom lectures and laboratory courses are open to all interested. Fees are charged for laboratory courses.

**SEMINARS** are held weekly in Anatomy, Pathology, Pharmacology, Physiology, Physiological Chemistry, Primate Biology, and Immunology.

## GENERAL

**M.S. and Ph.D. DEGREES.** Properly qualified persons may be eligible as candidates for the degrees of Master of Science (M.S.) and Doctor of Philosophy (Ph.D.). Requirements vary in the several clinical and preclinical departments. Inquiries should be addressed to the Dean of the Graduate School.

**THE LIBRARY** in Sterling Hall of Medicine. Open on weekdays, 8:30 A.M. to 9:55 P.M., and on Sundays, 2:00 to 9:55 P.M.; vacation hours, on weekdays, except Saturdays, 8:30 A.M. to 5:00 P.M.; on Saturdays, 8:30 A.M. to 1:00 P.M. Departmental collections supplement the general facilities.

**YALE MEDICAL SOCIETY.** Meets monthly from October to May on the second Wednesday at 8:30 P.M. Papers by members of the staff and by visiting lecturers. The programs are published in the *Yale University Bulletin*.

Other lectures by visiting scientists under the auspices of the Society are announced in the *Bulletin* and are open to all interested.

**NEUROLOGICAL STUDY UNIT.** Meets every two weeks from October to May at 4:30 P.M. in the Auditorium, Farnam Memorial Building: second Tuesdays for the presentation of neurological reports and discussions of data; fourth Tuesdays clinical session for the presentation of cases. In so far as possible programs will be published in the *Bulletin*.

**REGISTRY OF BRAIN TUMORS.** The collection of some two thousand brain tumors made by Dr. Cushing has been installed in the Department of Pathology, Brady Memorial Laboratory. It is hoped that this collection will be added to from many sources. Anyone who may feel inclined to send specimens for diagnosis or may seek information of other sorts is welcome to do so and should communicate with Dr. Louise Eisenhardt.

**EXHIBITIONS,** arranged in the Sterling Memorial Library throughout the year, are open to the public (see the *Bulletin*), besides other general University activities, many of which are free.



## • OBITUARIES •

### HENRY FARNUM STOLL, M.D.

1878 - 1936

It is with regret that the Hartford County Medical Association records the untimely death of Dr. Henry Farnum Stoll, on September 28, 1936.

Dr. Stoll was born in Port Jervis, New York, in 1878. After attending Cornell University he graduated from the College of Physicians and Surgeons, New York, in 1902. He then served his internship at the Hartford Hospital and, as have many others, decided to make Hartford his permanent home.

Soon his ability was recognized and he was made Assistant Visiting Physician to the Hartford Hospital in 1905 and Visiting Physician in 1923, which position he held at the time of his death. Dr. Stoll was Consulting Physician to the New Britain General Hospital, to the Windham Memorial Hospital, to the Manchester Memorial Hospital and to the Neuro-Psychiatric Institute of the Hartford Retreat.

During the World War Dr. Stoll distinguished himself as instructor in the diagnosis of Tuberculosis in the Army Medical School, in Washington, D. C., having a service at the Walter Reid Hospital. He was promoted to the rank of Major and after the war was made a Lieutenant Colonel.

Dr. Stoll was a member of the Hartford Medical Society, the Hartford County Medical Association, the National Tuberculosis Association and a Fellow of the American College of Physicians, being Governor for the State of Connecticut.

He was President of the Hartford County Medical Association in 1932 and at the time of his death was Vice-President of the Hartford Medical Society.

In 1911 he was married to Miss Eleanor Roberts who survives him.

He was always actively interested in the Hartford Medical Society and in the County Association, and presented many scientific papers before each of these societies.

His specialty of Internal Medicine brought him a large consulting medical practice, particularly in diseases of the lungs and syphilis. His mind was alert and active and he was ever on the search for the most recent scientific advances in medicine and the most modern method of treatment.

His personal charm and keen enthusiasm will be greatly missed by the members of the Society among whom he had so many friends.

Edward R. Lampson, M.D.

—☆☆—

### LeVERNE HOLMES, M.D.

1879 - 1938

While in the prime of his life and holding an enviable position of responsibility and honor, sudden death took LeVerne Holmes, of Manchester, Conn., on March 26, 1938.

Dr. Holmes was born in Richmondville, New York, August 22, 1879. He graduated from Boston University Medical School in 1904. He settled in Manchester in 1910 where he practiced until 1917. At the outbreak of the World War, in spite of good reasons for not doing so, he promptly volunteered for service. Following his service overseas he resumed his practice in Manchester in March of 1919.

In 1923 he was appointed Orthopedic Surgeon at the Manchester Memorial Hospital where his ability rapidly increased to such a point that, at the time of his death, he seemed almost indispensable. He was vice-president of the active staff, secretary of the Manchester Medical Association, member of the Hartford County and Connecticut State Societies, and member of Connecticut State Fracture Clinic.

He led a busy and useful life with his time not entirely devoted to medicine. He was vice-president of the Manchester Y. M. C. A., president of the Manchester Country Club, Medical Examiner for the Town of Manchester, and Medical Examiner for the veterans.

Dr. Holmes was a veteran of the Spanish-American and World Wars. In the first mentioned he saw active service in Hawaii. In the latter war he was commissioned 1st Lieutenant in the Medical Corps, assigned to the department of Orthopedic surgery and went overseas with Base Hospital No. 64. His work in this connection won him a captaincy. Following his discharge from the army he enlisted in the Re-



serves Officers Corps, where he was promoted until, at the time of his death, he was a Lieutenant Colonel, 76th Division Medical Corps.

The factual record of his life falls far short of giving a true picture of the man of whom we were so fond and in whose professional ability and sound judgment we had so much confidence. He was noted for never speaking ill of anyone, was modest almost to a fault, never self-seeking, honest in word and deed, dependable and blessed with a true sense of humor. To his patients he was sympathetic and untiring in his efforts to make them comfortable and well.

He leaves his wife, Mrs. Ruth (Wiswall) Holmes, and a daughter, Mrs. John Sinkinson, of Scarsdale, New York.

Howard Boyd, M.D.

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#### CHARLES KIRTLAND STILLMAN, M.D.

1879 - 1938

Charles K. Stillman was born at Plainfield, N. J., July 15th, 1879, the son of Dr. Charles F. and Harriet Edith (Greenman) Stillman. He died at Mystic, Conn., March 22nd, 1938. He was a graduate of the following schools: Cheltenham Military Academy, 1896; Brown University, Ph.B., 1900 (Phi Delta Theta); Columbia University Medical School, New York City, M.D., 1904; Interne, Bellevue Hospital, 1905-6. Practiced internal medicine, New York City, 1907-11; Mystic, Conn., 1912-17; U. S. A., 1918-19; First Lieutenant, U. S. A. Medical Corps, Oct. 25, 1918 - July 31, 1919; Service at Base Hospital, Camp Wheeler, Georgia; Assistant Chief of Medical Service, Consultant to surgical service, etc., General Hospital, No. 1, New York. General practice, Mystic, Conn., 1919-1928, retiring from active practice because of ill health. Member Connecticut State Medical Society, Fellow, A. M. A., Member New London County Medical Society, the Society of Alumni of Bellevue Hospital, New York Pathological Society and the Association of Military Surgeons of U. S. A. Clubs: Brown University, New York City; American Legion; American Game Protective Association, and Incorporator and Director of the Atlantic Tuna Club.

Dr. Stillman's death will be sincerely regretted by a host of classmates, medical associates and friends. A descendant on his mother's side of a long line of shipbuilding and seafaring ancestors

and on his father's of generations of professional and business men, he inherited from the one the huge frame and robust physique of the out-of-door man and from the other remarkable and unique intellectual capacities. He was especially fond of sailing and fishing and excelled in tuna fishing and dry fly casting. For years he gave voluntary and valued service to the Connecticut Commission for the Preservation of Fish and Game and his discoveries regarding the migration of Tuna fish played an important part in determining the origin of the species. He had artistic abilities of a high order, being responsible for a majority of the interesting and whimsical drawings in the Brown Liber of his class, later developing a genuine talent for landscape painting, which recreation he pursued until prevented by failing eyesight. His medical attainments were of the highest order. He received the highest possible grade in a competitive examination among hundreds of medical graduates in New York, winning the coveted appointment as medical interne at Bellevue Hospital. While in Bellevue and later he did research work of a character which is still spoken of with respect in medical circles. In particular, the publication of his studies on "Alcoholic Wet Brain" constitutes an outstanding contribution to medical science, changing all earlier theory as to the nature and causes of that disease. In 1928, when failing health compelled his retirement from practice, he turned to his early love — the sea — and spent the last years of his life collecting shipping relics, material and data, founding, in 1929, The Marine Historical Association, Inc., which, under his care and guidance, developed in a few short years into one of the leading organizations of its kind in America. An associate of long standing wrote recently: "Kirt" was the soul of honor and his friendly, winning personality and infectious enthusiasm are still vividly and affectionately remembered by a host of classmates and friends." It is given to but few to pass from the scene so deeply missed, or more universally regretted.

Louis M. Allyn, M.D.

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#### D. FRANK GRAY, M.D.

1863 - 1938

Dr. D. Frank Gray of 382 Thayer St., Providence, R. I., died suddenly April 21, 1938. Dr

Gray was called to see a patient, who died soon after his arrival. The doctor then sat down in a chair, saying, "I guess the exertion was a little too much for me," smiled and slumped forward dead.

Dr. Gray was born in Brooklyn, September 18, 1863, the son of the late John W. and Mary Spillane Gray. He attended public school in New York and after a year at Dartmouth College entered Bellevue Medical School. He served his internship at Blackwells Island and at Christ Hospital, Jersey City.

In 1898 Dr. Gray was married to Miss Anne Devereaux of this city and Springfield, Mass. She survives him as does their daughter, Mrs. Helen G. Jackson, wife of Prof. Joseph Jackson of Yale University.

Dr. Gray was on the staff of St. Joseph's Hospital, and was a member of the American Medical Association through its Rhode Island and Providence branches, and Tyler Council, Knights of Columbus. For 42 years he never missed a clinic or association meeting in this city and every week attended a clinic on Wednesday at the Boston City Hospital.

Dr. Gray was a regular attendant at the meetings of the Connecticut Clinical Congress from its inception and has served on the Program Committee.

Funeral services were held Monday morning, April 25, at his home, followed by a solemn high mass of requiem in Holy Name Church. Burial was in the family plot in St. Michael's Cemetery, Springfield.

Clarence E. Burt, M.D.

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#### FOURTH ANNUAL POST-GRADUATE INSTITUTE OF PHILADELPHIA COUNTY MEDICAL SOCIETY

The Philadelphia County Medical Society desires to announce formally, the completion of its scientific program for the Fourth Annual Post-graduate Institute to be held in the Bellevue-Stratford Hotel, Philadelphia, during the week beginning March 13th, 1939. The subjects to be considered are those embraced by the terms *Blood Dyscrasias* and *Metabolic Disorders*. These will be further subdivided for convenience in instruction into eighty-six clinical lectures, with open forum discussion for each topic, delivered by as many individual specialists of national distinction.

## • Quarto Notes •

### THE NEW BORN INFANT

A MANUAL OF OBSTETRICAL PEDIATRICS

by Emerson L. Stone, M.D.

Associate Clinical Professor of Obstetrics and Gynecology, School of Medicine

Yale University

291 Pages	2nd edition	\$3.00
Philadelphia	Lee & Febiger	1938

To bridge the gap in the new born infant's life from the time of birth to the age of four to six weeks, the author offers this very excellent book, suitably termed a manual of obstetrical pediatrics. The excuse for such a publication is the lack of supervision many new born infants receive when the obstetrician shows little interest in their welfare as soon as the cord is tied and separated and the respirations are proceeding in a normal fashion. In our larger and better equipped hospitals there is a happier co-operation between obstetrician and pediatricist resulting in the gradual and complete disappearance of this period of indifferent care of the infant. This volume in its second edition is so up to the minute that study of its contents by obstetricians and pediatricists alike should greatly improve the proper care of our new born infants and be of appreciable service in lowering the neonatal mortality and morbidity rates.

Particularly to be commended is the discussion of the modern methods of dealing with asphyxia found in Chapter I, the discussion of syphilis and the use of sulphanilamide in Chapter X, the modern concept of fetal respiration in utero as explained in Chapter XI, and the plea for hospitalization of all premature infants where the best in modern technique and equipment may be enjoyed. The detail of the text including breast feeding, modified feeding, dietary disorders and infections is given due importance.

For the obstetrician the chapters on birth injuries are especially to be commended. We believe the author should be more insistent on the use of cisternal puncture since it is an invaluable procedure and not too difficult for the attendant of good medical training. The group of erythroblastoses has received scant attention in this manual. It is an important pathological condition, even yet little recognized by the obstetrician upon whom rests the responsibility for immediate treatment if its mortality rate is to be lowered. Even with these few shortcomings the text is to be recommended for all physicians who are privileged to serve the new born infant.

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## SYNOPSIS OF CLINICAL LABORATORY METHODS

by W. E. Bray, B.A., M.D.

Professor of Clinical Pathology, University of Virginia

2nd Edition 498 Pages \$4.50

51 Text Illustrations 17 Color Plates

St. Louis The C. V. Mosby Co. 1938

The review of this book is from a clinician's viewpoint and not as a laboratory expert. It is of convenient size, practical, up to date and quite complete as a working clinical manual. Its content includes the examination of urine, blood, blood chemistry, gastric analysis, stools, puncture fluids, sputum, bacteriology with something about the higher bacteria, water and milk analysis, serology, basal metabolic rates, allergy tests, poisons, foreign substances, surgical pathology, and finally the preparation of laboratory reagents. The laboratory procedures indicated in diseases peculiar to various specialties are given. Several more or less accepted examinations have been added to this addition. Some of these are serum phosphatase determination, titration of staphylococcus antitoxin in blood serum, peroxidase Giemsa staining method, cough plate method for diagnosis of pertussis, opsonocytaphagic test of the immunity status in undulant fever, vitamin C titration, blood cyanates and sulphanilamide, heterophile agglutinations for infectious mononucleosis and morphine in the urine.

The book is a useful guide to the clinician or laboratory worker.

J. A. Wentworth



## PRACTICAL MICROBIOLOGY AND PUBLIC HEALTH

for Students of Medicine, Public Health and General Bacteriology

by William Barnard Sharp, S.M., M.D., Ph.D.

Professor of Bacteriology and Preventive Medicine  
Medical Department, University of Texas

125 Illustrations 485 Pages \$4.50

St. Louis C. V. Mosby Co. 1938

This book is essentially a laboratory manual, using the word "laboratory" in the broadest sense to include the field trip, the health office and the clinic. The objective is to guide the student's observation, to suggest a working schedule and to provide forms for entering data. All phases of public health activity are covered: administration, education, epidemiology, sanitation, vital statistics and, particularly, bacteriology, immunology, parasitology and mycology.

The book will be welcomed by those educators who believe that the student should get out into the world, should put himself in the situation he proposes to study, in this instance to live the life of the public health official.

While the book appears to be adequate for the student in the usual medical course, certain sections, as those on vital statistics and sanitation, would obviously be too brief for students planning to specialize in the field of public health. Interpretative comments are interspersed throughout the text. Of these the several paragraphs summarizing the purpose and status of the periodic health examination are unusually well done.

The author fully intends that the manual be used to supplement other instruction in public health. However vitalizing laboratory experience may be, there is danger in too much practicality. The educator owes it to his students through textbook and periodical, through lecture and seminar to broaden their point of view, to open up new vistas.

C. Kuh



## A SYNOPSIS OF THE DIAGNOSIS OF THE ACUTE SURGICAL DISEASES OF THE ABDOMEN

by John A. Hardy, M.D., F.A.C.S.

El Paso, Texas

345 Pages 92 Illustrations \$4.50

St. Louis C. V. Mosby Co. 1938

This book is one of the popular synopsis series published by the Mosby Company. The text is quite complete and well arranged, with sub-headings for etiology, history, the various signs, symptoms, etc. The illustrations are drawings and diagrams, well executed and annotated to help clarify the problems at hand. Stress has been properly placed on the disease signs and symptoms "that may be seen or felt or heard." Not only the surgical emergencies requiring immediate intervention are considered, but also the differentiation of zoster, plumbism, etc. Banti's disease and hemolytic jaundice, which under certain circumstances are surgical conditions, are also discussed, but with little said of when or whether to operate. This is consistent with the scope of the book, however, as it concerns only diagnosis. The indexing is well done, but might have been even better. For example, leucocytosis lists 21 page numbers without indicating the conditions in which it is encountered. This volume doubtless will be a useful addition to most libraries, particularly for general practitioners who do abdominal surgery to whom it is largely addressed by the author in his preface.

D. M. Beckwith



## DANGEROUS DRUGS

Since the passage of the new Federal Food, Drug and Cosmetic Act, the Food and Drug Administration at Washington has issued notices dealing with a number of very important drugs.

The first, under date of August 26th, covered sulfanilimide and stated in part: "It is the consensus of qualified experts that sulfanilimide is a valuable aid in the treatment of certain serious disease conditions when the dosage is properly directed . . .; under other conditions, it is a dangerous drug . . .". Sulfanilimide and drug preparations containing sulfanilimide sold for individual use to the general public are, when found in interstate commerce, actionable under sections of the new Act now in effect.

(Continued on Page 48)



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### **SYMPOSIUM ON BEHAVIOR PROBLEMS IN CHILDREN**

*(Continued from Page 18)*

cannot help, though, expressing a certain feeling of guilt on my part. It occurred to me that it may not have been fair to ask our colleagues here to talk to us for 10 minutes each, as it does not seem to be possible for anybody who has been working in his field for years, to give one very much of an idea of what he has in mind, in such a short span of time.

In view of this situation my gratitude, and I trust the gratitude of the audience, towards our five colleagues is the greater. Dr. Gesell has given us a broad and profound background of his concept of development. Dr. Ilg has been ably emphasizing the developmental sequence. Dr. Orton has presented us with a multitude of facts from his unique workshop. Dr. Cunningham impressively stressed the problems that older children meet with, and Dr. Salinger, coming as it were directly from the battlefield, was not afraid to explode a little bomb!

I want to thank our colleagues once more and I want to thank you who have been listening to them.

—☆☆—

### **DANGEROUS DRUGS**

*(Continued from Page 47)*

Another notice, issued September 8th, advises that cincophen, neocincophen and aminopyrine are, when found in drug preparations in interstate commerce under labelings which may result in their use by the general public, also actionable under that section of the new Act which deals with traffic in dangerous drugs. Cincophen has been reported in medical literature as causing numerous cases of acute yellow atrophy and cirrhosis of the liver, which result in permanent damage and, not infrequently, in death. Aminopyrine has been recognized as a most important causative factor in agranulocytosis.—*Bulletin of the Dept. of Health, Kentucky.*

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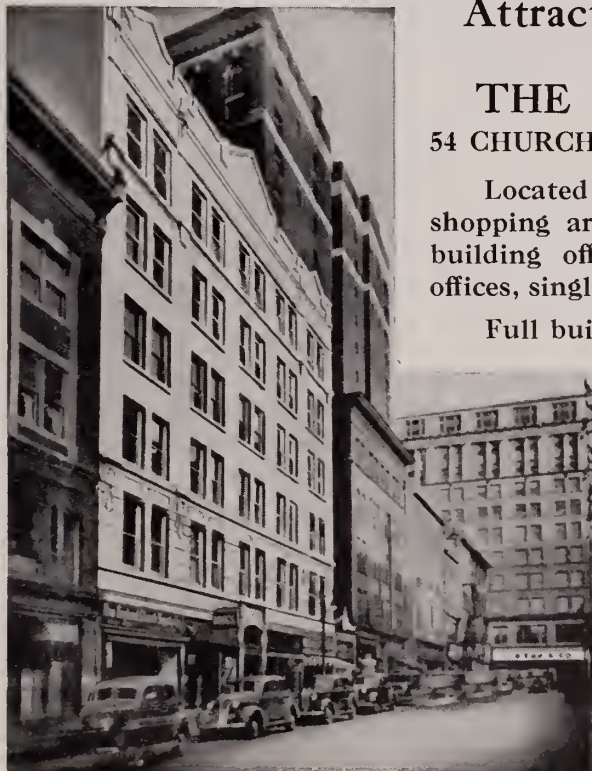
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## THE EIGHT POINT PROGRAM OF THE AMERICAN SOCIAL HYGIENE ASSOCIATION

(Continued from Page 30)

gressive step. The present law has been held up as a model from which it is hoped every state will construct similar legislation.

America's best opportunity to conquer syphilis is at hand. The Association through its hundreds of affiliated and cooperating organizations is doing its part to the limit of its present resources of time, energy and money. The full and spirited cooperation of all agencies and individuals is essential if syphilis and gonorrhea are to be materially reduced or eliminated within a single generation.



## PNEUMONIA SERVICE OF BUREAU OF LABORATORIES

(Continued from Page 32)

Through the Bureau of Laboratories the State Department of Health is attempting to give the best laboratory diagnostic service for pneumonia that can be offered while Federal funds are temporarily available. The success of the program will depend upon the use made of it by physicians and upon how well it meets a need. All available means have been made use of to notify physicians and health officers that this service exists. It is hoped and expected that the service will be used by every physician who does not have nearer at hand the services of one of the laboratories approved by the Department for pneumonia typings. Some of the smaller laboratories that have been approved for Neufeld tests are not in a position to offer a blood culture service and some of the laboratories do not have mice on hand at all times for confirming the diagnosis by animal inoculation. In such instances the central laboratory may be of service for additional laboratory services in pneumonia that are not offered locally. It is recognized that the prompt use of laboratory facilities in the diagnosis of pneumonia and the use of the proper type of therapeutic serum will save lives. The expected lowering of the death rate may eventually reflect how fully the services offered by the State of Department of Health have been taken advantage of by physicians.

## NATION-WIDE TUBERCULOSIS PROGRAM PROPOSED

A proposed new program, nation-wide in scope, looking toward the eradication of tuberculosis in the United States was presented at the annual meeting of the National Tuberculosis Association in Los Angeles on June 20, 1933. This program, which has the endorsement of Surgeon General Thomas Parran, Jr., was presented in the form of a progress report of a committee of which Homer Folks, Secretary of the New York State Charities Aid Association, is chairman.

The suggested program, to start in 1939, would require \$140,000,000., for the construction of 40,000 hospital beds for tuberculosis patients. Another part of the program is to X-ray all persons who have had family contact with known cases of tuberculosis, at an estimated cost of \$5,544,000 for 792,000 examinations. It is suggested that there should be a larger proportion of Federal financial participation in construction costs than in maintenance costs, and that Federal grants toward hospital maintenance be made at the basic rate of 50 per cent during the 6 years covered by the plan. (An outline of a Suggested Nation-wide — Federal, State, Local — Program to Prevent Tuberculosis. National Tuberculosis Association, 50 West Fiftieth St., New York. 1938. 12 pp.).—*The Child*, August, 1938.



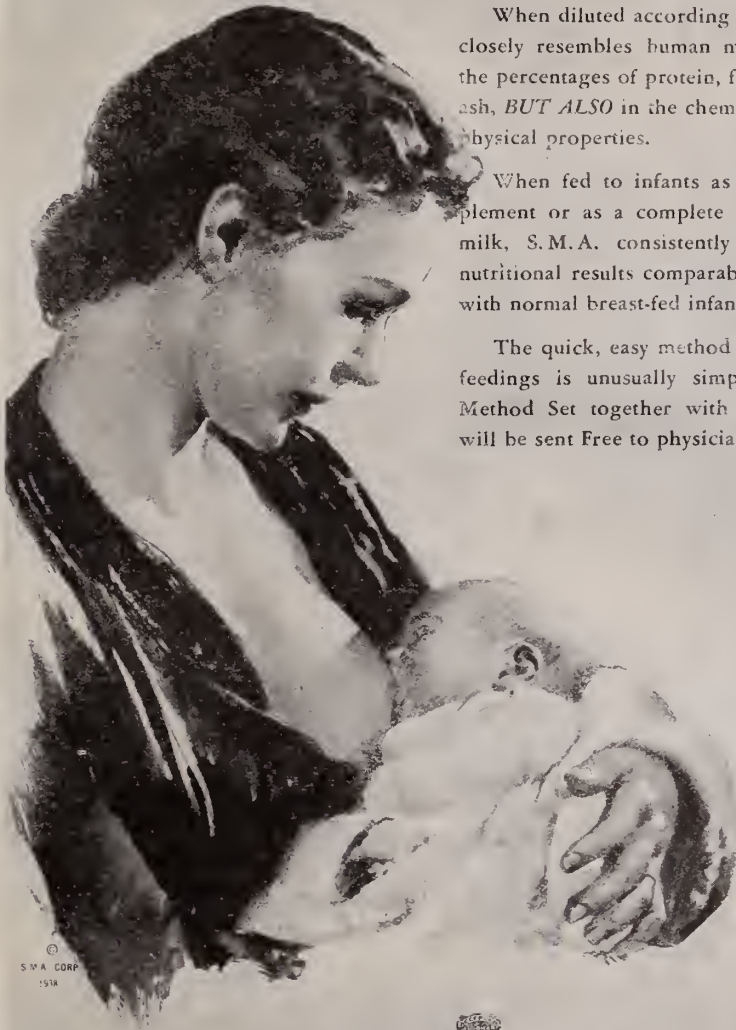
## FEATURES OF THE NEW YORK WORLD'S FAIR

The relaxing and pain-eliminating effects of anaesthesia are to be demonstrated in the Medicine and Public Health Building of the New York World's Fair 1939 through use of a full-size mechanized model of a human being lying upon an operating table, surrounded by animated figures of surgeons, nurses and others.

The first automobile X-ray unit in existence — a gleaming new streamlined automobile devoid of windows but containing an elaborately equipped photographic darkroom and the last word in portable X-ray equipment — will be used at the New York World's Fair. The mobile X-ray unit will be called into service in cases involving fractures or possible fractures, or other internal injuries.



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In depressive states, the suitability of 'Benzedrine Sulfate' (amphetamine sulfate, S.K.F.), as well as its correct dosage, must be determined for the individual patient.

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Initial dosage should be small, ranging from a minimum of 2.5 mg. ( $\frac{1}{4}$  tablet) to 5 mg. ( $\frac{1}{2}$  tablet). These should be regarded as test doses, and if no effect is obtained from the smallest amount given, the dosage may be progressively increased until a definite effect manifests itself. Usually it is unnecessary to give more than 10 mg. at a single dose. Careful medical supervision during this test period is particularly desirable.

When the correct dosage has been determined, it may be given two or three times a day, bearing in mind that administration in the late afternoon or evening may interfere with sleep. When divided doses are required, the specially grooved tablet may be broken and one-half or one-quarter tablet given.

The effects of 'Benzedrine Sulfate', whether desirable or undesirable, are usually apparent with the first few doses. If there are undesirable effects 'Benzedrine Sulfate' obviously should be discontinued.

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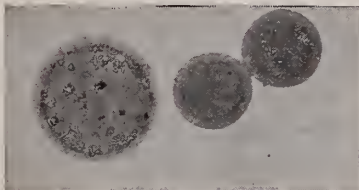
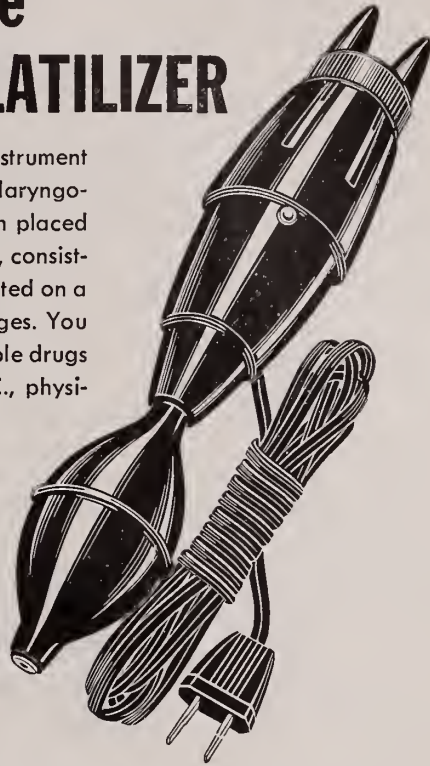
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\*Windwer and Matzner, *Am. Jl. Dig. Dis.*

WRITE DEPT. 458

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**Ipral Calcium** (calcium ethylisopropylbarbiturate) is supplied in 2-gr. tablets and in powder form for use as a sedative and hypnotic, and in  $\frac{3}{4}$ -gr. tablets for use where it is desired to secure throughout the day a continued, mild, sedative effect.

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Joseph L. Daly, New York  
Dwight E. Wilson, Penn.  
James W. DuShane, Conn.  
Fernald Fitts, Rhode Island  
Edwin D. Flanagan, New York  
N. Edward Gourson, Conn.  
Volta Ross Hall, Mass.  
Wendell C. Hall, Texas  
George W. Hebard, New York  
William Koufman, Mass.  
Marjorie S. Knauth, New York  
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Christie E. McLeod, Vermont  
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Paul L. Phillips, Conn.  
Frederick J. C. Smith, Kansas

Horace E. Thomas, Conn.

Paul W. Tisher, Iowa

Robert L. Wagner, Cal.

T. P. Murdock, M.D.

Secretary

—☆☆—

## DIABETES MORTALITY

In practically all parts of the world diabetes death rates have risen almost continuously. In the last five years the average increase throughout the world is close to 20 per cent. Over the last 15 years increases as large as 50 per cent or more are common.—*Baker Clinic, Boston.*

—☆☆—

WHAT EVERY WOMAN DOESN'T KNOW —  
HOW TO GIVE COD LIVER OIL

Some authorities recommend that cod liver oil be given in the morning and at bedtime when the stomach is empty, while others prefer to give it after meals in order not to retard gastric secretion. If the mother will place the very young baby on her lap and hold the child's mouth open by gently pressing the cheeks together between her thumb and fingers while she administers the oil, all of it will be taken. The infant soon becomes accustomed to taking the oil without having its mouth held open. It is most important that the mother administer the oil in a matter-of-fact manner, without apology or expression of sympathy.

If given cold, cod liver oil has little taste, for the cold tends to paralyze momentarily the gustatory nerves. As any "taste" is largely a metallic one from the silver or silver-plated spoon (particularly if the plating is worn), a glass spoon has an advantage.

On account of its higher potency in Vitamins A and D, Mead's Cod Liver Oil Fortified with Percomorph Liver Oil may be given in one-third the ordinary cod liver oil dosage, and is particularly desirable in cases of fat intolerance.

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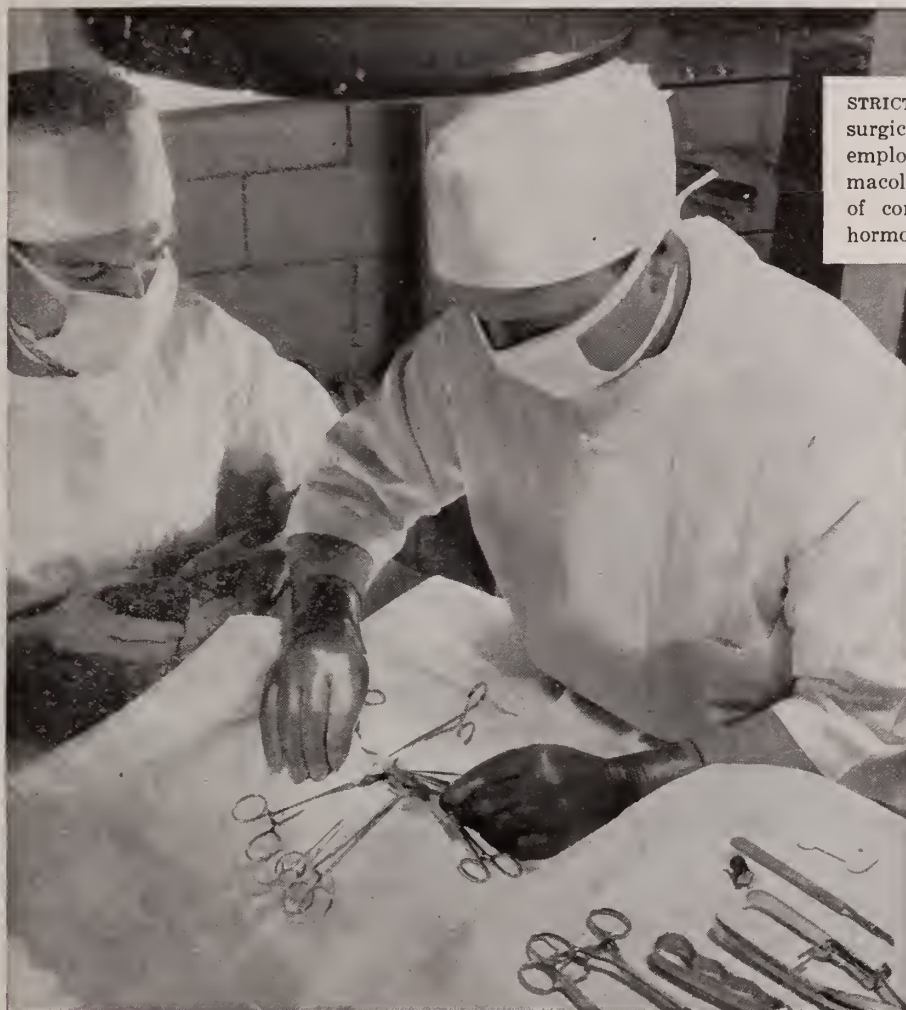
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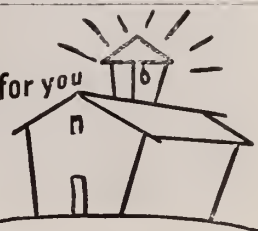
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THE YOUNGSTER in the picture isn't terribly sick.

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Throughout the next six or eight weeks especially, it will be wise to

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But above all, if anyone in your family has a cold and his or her temperature rises above normal, don't delay! Call your physician at once. Watch out, too, for chills, pain in the side or chest, and a cough. They, also, are danger signals that should be heeded promptly.

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# JOURNAL of The Connecticut State Medical Society

Owned and Published Monthly by  
THE CONNECTICUT STATE MEDICAL SOCIETY

Editor-in-Chief - STANLEY B. WELD, M.D.,  
54 Church Street, Hartford, Connecticut

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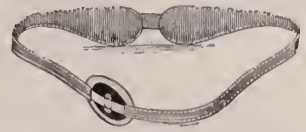
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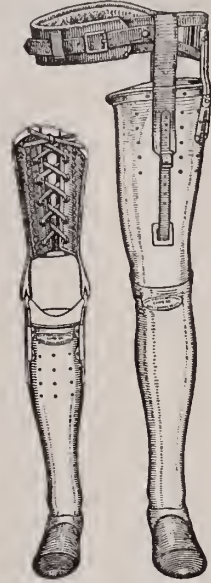
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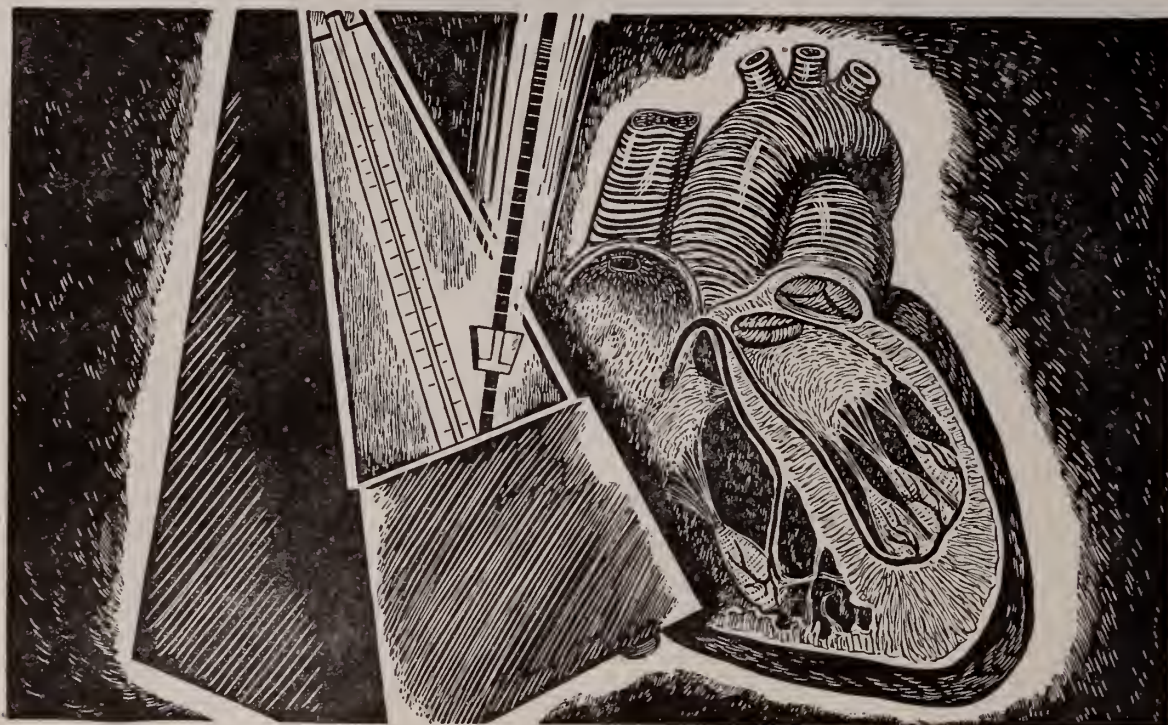
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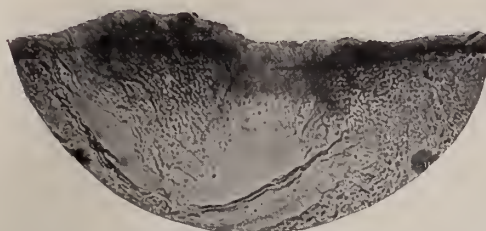
1 cat unit = 1 tablet = 1 cc. liquid = 1 ampule  
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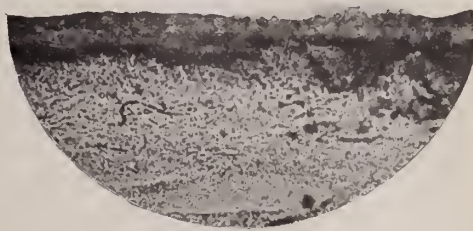
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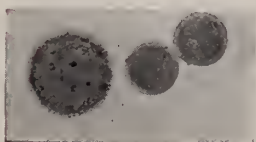


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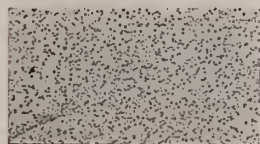
## Designed to Supersede Dropper and Atomizer ... TORVIC ELECTRIC VOLATILIZER

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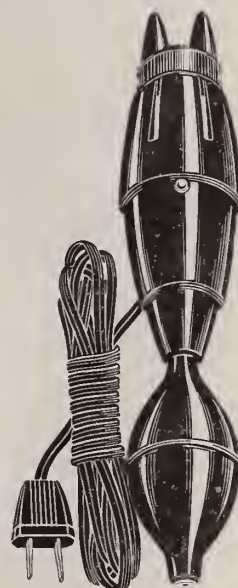
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## IMMUNE GLOBULIN (Human)

*Lederle*

FIVE YEARS OF CLINICAL STUDY and laboratory investigation of this serum have proved its value in the modification of the attack and the lessening of the dangerous complications of measles.

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There is no satisfactory evidence available that an attack of measles can be modified by administration of any practical dose of Immune Globulin (Human) after the characteristic symptoms of the disease have appeared.

<sup>1</sup> Levitas, Irving M.: Treatment, Modification and Prevention of Measles by Use of Immune Globulin (Human), J.A.M.A., 1935, 105, 493.

<sup>2</sup> Laning, G. M. and Horan, T. N.: Immune Globulin Used as a Preventive and Modifier of Measles, Jour. Mich. Med. Soc., 1935, 34, 772.

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HIS EXCELLENCY, GOVERNOR RAYMOND BALDWIN

*A MESSAGE  
FROM THE GOVERNOR*

To the Editor of The Journal:—

I thank you very heartily for your kind letter of congratulation. I shall welcome your cooperation and support because I know that it will be most helpful in the days ahead.

Congratulations are due to the medical profession for the splendid services it has rendered throughout the years. Without thought of personal gain and at great sacrifices to personal health, its members have worked tirelessly to make life longer and easier for us all.

I extend to the members of the medical profession, to the staff of the Journal of the Connecticut State Medical Society and to you personally my heartiest best wishes for happiness and success in the year and years ahead.

Yours very sincerely,

RAYMOND BALDWIN

# JOURNAL of The Connecticut State Medical Society

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No. 2

## Mesenteric Cysts

RICHARD E. DUNNE, M.D.  
Hartford, Conn.

As the name implies, mesenteric cysts are cysts in the mesentery and may occur anywhere throughout its length, at any age and of any size. The first mention of this condition in the literature was by Benivieni, a Florentine anatomist, in the 16th century as an anatomic curiosity and his report in 1507 contains observations and discussions by Lupius, Morgagne and others. As pointed out by Judd and Heimdal, who report eleven cases of mesenteric cysts in the Mayo Clinic records, the particular points centering around cysts of the mesentery are their extreme rarity, their debated origin, their disputed classification, the infrequency with which they are recognized preoperatively, and their part in causing intestinal obstruction.

Cysts of the mesentery are undoubtedly among the rarest tumors encountered in the field of general surgery. In most textbooks the condition is dismissed with a fleeting mention or a cursory description. VenderVeer describes a small serous cyst in the mesentery of the small bowel in 1911. Collins and Berdez report that not a single case of chylous cyst was found in 15,000 necropsies at the University of Minnesota, and they further state that in searching the records of St. Mary's and St. Luke's Hospitals in Duluth only two cases of chylous cysts were reported in 200,000 cases. Alesen was unable to find any case of mesenteric cyst of any type at the Los Angeles General Hospital during the years 1912 - 1929, a total of 17 years. Writers disagree on the number of cases of these cysts recorded in the entire literature, usually placing the number between 200 and 400. Eugene O. Parsons in a complete search reports finding 500

cases of mesenteric cysts in all, but many of these were probably improperly classified, as in this list are included retroperitoneal and peritoneal tumors, both malignant and benign, undergoing stages of cystic degeneration. Benedict and Friedn independently reviewed the literature. The former found 79 cases, and the latter reported 52 cases which he gathered. In their lists, which overlap considerably, many of the very earliest cases reported are included and it would seem that some of the diagnoses are open to question. Benedict concludes from his analysis of his series, that there is no age incidence. They occur or are found at any age equally among males and females.

Just what constitutes a retroperitoneal tumor on the one hand and a true mesenteric tumor on the other rests probably on the general direction the tumor selects to grow,— if backward and upward along the mesenteric border, it becomes a retroperitoneal tumor,— if forward, a mesenteric tumor. These tumors can be classified only as mesenteric cysts if they undergo cystic degeneration, and strictly speaking are not primarily cysts but degenerating tumors.

Bearing these facts in mind, a true mesenteric cyst is undoubtedly a rarity. Because of the rather unique experience in encountering and operating on two of these cases within a space of two weeks after a previous negative surgical experience extending over eighteen years these two cases of true mesenteric serous cysts are reported in some detail.

### Case No. 1

Mrs. M., age 63, was referred from Westfield, Mass., for a complete general check-up. She was known to have a hypertension and a marked constipation accompanied



by vague general symptoms of nervousness, fatigue, moderate indigestion, vertigo, and insomnia. She had no regional symptoms directly referable to her abdomen. She had been treated as a hypertensive case.

On physical examination, she was a stout, florid, elderly woman with a rather prominent abdomen. Her general examination was essentially negative except for a slight elevation of blood pressure of 160 systolic and diastolic of 80. Heart sounds were regular and normal, it was not enlarged. Lungs and chest were normal. A large tumor was felt in the LLQ which was smooth in outline and appeared to be only slightly movable. It reached over slightly beyond the midline and almost to the umbilicus and appeared to come up from the pelvis. The percussion note over this area was absolutely flat, there was no spasm nor tenderness even on deep pressure. A diagnosis of large left ovarian cyst was made. Pelvic examination was essentially normal. The left vault was bulging a little but no definite mass was palpated. Pressure on the abdomen from above brought a cystic type of tumor within reach of the examining finger. It was felt that we were dealing with an ovarian cyst, which had become so large as to rise out of the pelvis and rest in the lower abdomen, just above the pelvic brim. The laboratory work showed a normal blood and urinary picture. She was operated upon on December 6th, 1937, through a low midline incision. On opening the abdomen, a very large, cystic mass was seen and felt occupying practically the entire lower left quadrant of the abdomen. It was completely covered over by a large, redundant section of the large bowel, which proved to be sigmoid and descending colon and their mesentery. It was firmly incorporated in this mass of bowel and mesentery, and there appeared no line of cleavage anywhere. It was whitish-yellow in appearance, quite unlike an ovarian cyst. Uterus, tubes and ovaries were found to be small and atrophic. At first a retro-peritoneal cyst was considered but on opening the anterior layer of mesentery it shelled out very easily and quickly without any bleeding. The walls were extremely thin, almost tissue paper in thickness. There was no pedicle.

After removal, the cyst site was easily identified as between the anterior and posterior sheath of the mesentery of the sigmoid. The cyst weighed  $3\frac{1}{2}$  pounds, and was filled with a thin, yellowish, serous fluid.

Pathological Diagnosis made by Dr. L. P. Hastings was Benign Mesenteric Cyst. The specimen was described as a thin-walled, globoid cyst  $18 \times 15$  cm., distended with clear fluid and weighing  $3\frac{1}{2}$  pounds.

Patient made an uneventful convalescence and was discharged home on the 11th post-operative day.

#### Case No. 2

Is a child  $4\frac{1}{2}$  years of age, weighing 42 pounds, with a history of a gradual abdominal enlargement which began at the age of approximately  $1\frac{1}{2}$  years of age — for a period of 3 years. For the past year the enlargement had remained practically stationary, probably because "there is a limit to all things." The abdomen could not become any more enlarged. Its capacity had been arrived at.

During these 3 years, patient had been under more or less constant observation without a diagnosis ever having been arrived at. Celiac Disease, Hirschprung's Disease and Tubercular Peritonitis had all been considered. He

was admitted on the Pediatric service, with the above history, in December 1937.

His past history was essentially negative except for the above history of gradual abdominal enlargement for three years. Birth was normal, he had not been an abnormal feeding problem, his nervous, mental, and muscular development had been normal. His GI history was not unusual. There were no cardiovascular symptoms nor signs. The GU syndrome was negative throughout. He was a perfectly normally acting child in every way.

His physical examination was not remarkable, except for a very marked abdominal enlargement, which was so marked and had been so slowly progressive in type that his gait in walking was quite characteristic in his effort to overcome the handicap of the enlarged abdomen. There was a marked lordosis of the lumbar spine and he walked with a rolling, lumbering gait in an effort to carry and throw his abdomen forward as he walked. Locally, his abdomen was enormously distended, was flat to percussion, but was surrounded by a resonant note — a perfect circle of resonance, particularly in the upper right and left quadrants. There was a very definite fluid wave present, but the significant fact was there was no shifting dullness.

#### Laboratory Work

Blood: — RBC	4,200,000
Hgb	73%
WBC	7,800

Stools — negative for blood.

Icterus Index — 5 units (normal).

Urine — clear, amber, negative for albumen and sugar.

Sp. Gr. 1023, RBC and WBC negative. Bile test negative.

Tuberculin tests reported negative.

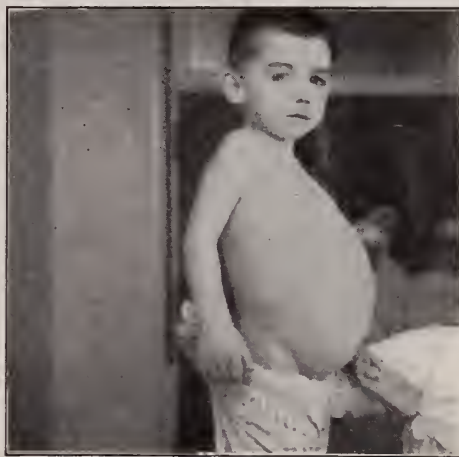


Fig. 1

Lateral view of the patient showing lordotic curve of the spine and the huge, pendulous abdomen producing the rolling gait in walking.

#### X-Ray Report

The GI series was reported as follows:—

Intrathoracic contents are normal. Patient unable to take but a portion of the barium mixture. Stomach is

226-764



Fig. 2

Lateral view in reclining. Abdomen was flat to percussion with a definite fluid wave and a circle of resonance around the circumference of the abdomen.

high under the diaphragm, due to large amount of fluid underneath pushing it up. Pylorus could not be outlined. Abdomen greatly distended from fluid.

6 Hour Plate:—Entire stomach is empty. Entire meal is contained in the RUQ. Intestines are pushed superiorly and laterally by an area of homogenous density that extends practically through the entire abdomen.



Fig. 3

Showing the stomach, immediately after ingestion of barium, crowded into the upper left quadrant of the abdomen with a homogeneous density filling the entire abdomen.



Fig. 4

Shows the 6 hr. plate after the ingestion of barium. The meal is in bowel and pushed to the upper right quadrant of the abdomen by the area of homogeneous density. Several films taken at this time showed the definite, constant position of the bowel in this area. Bowel did not float about through the area of density but was fixed.

24 Hour Plate:—Large bowel well filled, but displaced upwards, downwards and laterally by an area of homogenous density occupying entire abdomen.

When this child was seen in consultation by the surgical service it appeared that the main question for decision — one that would shorten the academic debate on a differential diagnosis a good deal — was whether the fluid contained in the abdomen was ascitic fluid or fluid constrained or contained in a sac. The following consultation note on Dec. 17th was made:—"The gradual abdominal enlargement over a 3 year period with a definite fluid wave and complete absence of shifting dullness with a persistent, constant displacement of the bowel by X-ray, means nothing but a large abdominal cyst — most likely mesenteric. Fluid is contained and not ascitic. Advise exploration."

Exploration was performed on Dec. 20th, 1937, under ether anesthesia. A left midrectus incision was made, and on opening the abdomen a huge cyst filling the entire abdomen was found, covered over by large and small bowel and mesentery. It was found necessary to extend the incision upward and downward. The anterior layer of the presenting mesentery was opened and the cyst was gradually shelled out. The cyst was so large that, as it grew, it had become lobulated to adapt itself to the abdominal outlines; i.e., one lobe ran into the pelvis to fill it, and another in the upper left quadrant of the abdomen, etc., and many of these projecting lobes, as they grew, had



become adherent to one another infolding the large mesenteric vessels. In removing the cyst intact, these lobes had to be separated from each other, and then dissected off the mesenteric vessels which, in some instances, they almost completely encircled. The cyst was so large and thin walled that it was necessary to allow it to fall into a basin and gradually allow the entire cyst to fall into the basin as it was peeled out, so decompressing the abdomen slowly. The walls were so thin that it was necessary to constantly moisten them as exposure to the air dried them very quickly and rupture of the cyst wall was feared. After removal, it was found to have developed in the mesentery of the sigmoid in almost the identical location as Case No. 1, just described.

Immediately after removal, cyst was weighed and found to weigh 10 pounds, which was practically  $\frac{1}{4}$  of the child's entire body weight.

Pathological Diagnosis made by Dr. L. P. Hastings: Benign Serous Cyst (Mesenteric). The specimen was described as a lobulated, thin walled cyst, weight 10 pounds. Surface was marked by numerous trabeculae of fibrous tissue. Wall was transparent and through the wall one could see fluid in which numerous crystalline substances were floating.

Uneventful convalescence took place. Patient was discharged on his 19th post-operative day.



Fig. 5

View of cyst immediately post-operative. Note extravasation of fluid through walls of cyst which were still intact, also the lobulated effect.

It was felt that some supportive orthopedic treatment would be necessary to correct the postural deformity but correction has taken place normally without any orthopedic appliance. At the present time, his posture, growth and development are normal.

### Classification

The rarity of these cysts has been mentioned. Various classifications have been offered in an attempt to explain their etiology, but it is obvious that the origin of mesenteric cysts has not



Fig. 6

Further illustrating lobulated effect. Small lobe had formerly entirely filled the pelvis.

been proven. Rokitsansky first accurately described a chylous cyst in 1822 and he believed mesenteric cysts developed from degenerated lymph nodes, and in 1887 Virchow concurred in his opinion.

In 1892 Brachehaye classified mesenteric cysts as follows:

1. Sanguinous cysts — usually traumatic and occurring as diffuse hemorrhage into the mesentery, or into pre-existing cysts or into solid tumors.
2. Lymphatic cysts — comprising the chylous and most of the serous cysts. They arise in thoracic duct, in the chylous vessels or in the lymphatic glands or vessels in the mesentery.
3. Congenital cysts, chiefly dermoid.
4. Parasitic cysts.

Moynihan presented a classification based on their contents — such as serous, chylous, hydated, blood, dermoid and cystic malignant disease.

Dowd in 1900 classified them as follows:

1. Embryonic cysts: (a) dermoid, (b) serous, (c) chylous, (d) hemorrhagic, (e) enteric.
2. Hydatid cysts.
3. Malignant cysts.

Hill in 1930 presented what is now a universally accepted classification. It is an adaptation of Dowd's classification. The basis of this classification is that they are all congenital and are of two types, Simple and Neoplastic. Under the Simple types are the serous, chylous and irregu-



lar types, as the occlusion of Meckel's Diverticulum. Under the Neoplastic type are those from the ectoderm, (dermoids), mesoderm (lymphangiomas), the entoderm (enterocystomas) origin and the teratomas from foetal inclusions.

This classification is a useful one to catalogue any cases we might see. Both of these cases herein reported are simple congenital cysts of the serous type. This classification, however, will not aid in understanding the etiology. So many different and conflicting opinions are advanced in the literature that obviously they must not be correct and we must admit that the etiology is not yet proven.

### Diagnosis

Eugene Parsons, writing in the *Annals of Surgery* in 1936, states that it had been frequently claimed that the diagnosis of mesenteric cyst has never been made prior to operation. He found four cases in the literature where the diagnosis was made preoperatively and substantiated at operation. Of the four, three diagnoses were made clinically by the process of exclusion, and one was made by X-ray studies alone. Diagnosis on Case No. 2, presented herein, was made on the large mass in the abdomen, the prolonged history, dullness to percussion surrounded by a ring of resonance, definite fluid wave, lack of shifting dullness and the constant fixed displacement of bowel.

There are no definite signs nor symptoms pathognomic of the condition. The outstanding symptom is a palpable mass which may be in any location in the abdomen. Pain may be entirely absent, as in these two cases. Gradual enlargement, displacement of bowel by X-ray, fluid wave which does not shift, are helpful signs, but depend greatly on the size of the tumor. Small ones will shift and be movable with the mesentery they lie in.

They can easily give signs and symptoms of intestinal obstruction, but it is rather the end result of their presence that is diagnosed here. The mechanics of intestinal obstruction may vary considerably — it may be rapid or chronic.

Jewesbury reports a case of intestinal obstruction in a child of five years from a volvulus. A large cyst was found two feet above the ileocecal valve and the bowel had rotated about the cyst. Eve, 1898, reports two cases — one in an infant eleven weeks old, and one in a child of three.

Both were admitted with a diagnosis of intestinal obstruction which was found to be due to the pressure of the cyst. Pressure of the cysts producing obstruction must be considered a late manifestation. Adhesions developing and involving the abdominal viscera can produce gradual obstruction. Rupture of a cyst from trauma resulting in an entanglement of coils of bowel in an obstructed mass can also develop, as in case reported by Pederson in a girl of seven. Emaciation may also be an outstanding symptom, if cysts are of the chylous type, and is due to gradual starvation.

### Treatment

The treatment of these cases is surgical. In the Simple cysts, as serous or chylous, enucleation is the operation of choice. This is done easily and with little or no hemorrhage. It must be recognized and the anterior or presenting layer of mesentery picked up, opened, and the cyst shelled out. In the neoplastic type, enucleation with resection of bowel is the indicated procedure. Other methods one sees advanced in the literature as drainage, aspiration and marsupialization have been outdated by modern surgery, although some cures have been reported by the latter procedure in the older reports.

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# Testosterone for the Treatment of the Eunuchoid State\*

K. W. THOMPSON, M.D.,†  
New Haven, Conn.

Testosterone, the most active of the known androgens (male sex-hormones), became available for clinical tests in 1936. The commercial preparation of this hormone from cholesterol had been made possible by chemical methods developed by Butenandt and Hanisch and by Ruzicka and Wettstein. The drug is most effective in the form of testosterone propionate dissolved in a vegetable oil. The hormone of such a preparation is slowly absorbed into the blood stream from the site of injection, and thus a maximum effect is exerted over a prolonged period of time in a manner which can be compared to the long acting protamine insulin. Testosterone may not be the natural form of the male hormone in man, but in experimental animals it is an almost perfect substitute for the natural male hormone.

The announcement of the preparation of this synthetic hormone was greeted with special interest by physicians who occasionally are called upon to treat eunuchoid patients. The results of this therapy in our patients and those reported in the literature are summarized briefly as follows:

The greatest success with this drug has been obtained in eunuchoid patients who have either failed to attain normal sexual development or who have been castrated by accident or surgical necessity. The optimum dosage for an eunuchoid adult is approximately 50 to 75 mgm. of testosterone propionate weekly, divided in two or three doses. After a preliminary saturation with the hormone, the maintenance dose may be lowered somewhat, but some of the patients have slowly developed a tolerance so that later the maintenance dose has had to be raised. The patients are instructed to inject themselves, and they adjust the dosage to their needs. The beneficial effects noted 2-10 days after starting the injections are the following:

1. The skin and mucous membrane of the penis become thickened; the pigmentation of

the skin of the genitalia is increased. One observer has reported a sudden tanning of body areas which had been exposed to sun-light prior to the hormone therapy.

2. Erections and glandular secretions appear.

3. Psychic changes occur involving an increase of interest in the opposite sex and an increase in the ambition, initiative, and self-confidence.

4. There is greater physical vigor, with a decrease or cessation of headaches, lassitude, and other neurasthenic complaints.

To be noted in the period of 10 days to three months after starting treatment are the following further changes:

5. The penis and scrotum increase in size, and scrotal function returns. The growth of the genitalia may be minimal in those patients who receive treatment when the growth period has long since passed.

6. A growth of hair may occur on the face, pubis, arms, and thighs. A growth of the beard and the pubic hair has not occurred in all patients.

7. A deepening of the pitch of the voice has been noted in most of the reported cases. Sometimes it has been a striking phenomenon, while in some cases the voice merely becomes husky, as if the patient had a respiratory infection.

8. A gain of 5 to 20 lbs. in body weight occurs, and this is accompanied by a retention of water, nitrogen and salt.

Cessation of the treatment is followed in 5 to 10 days by a regression of most of the beneficial effects. The mucous membrane and skin of the penis become thin while this organ becomes smaller, the headaches and lassitude return, and the erections cease. Our first patient in particular has lost his self-confidence and energy during intervals of no treatment.

Excessive doses of the hormone have produced priapism, an increase in body weight and a generalized puffy edema, acne of the face and

\*Read at the 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.

†Assistant Professor of Surgery, Yale University The School of Medicine.



trunk, and precordial pain. The latter symptom was so pronounced in one reported case that the treatment had to be abandoned. No other untoward results have been reported following this hormone therapy, but it is quite evident that more time must pass in order to evaluate the results and the dangers of the treatment.

Our opinion of the value of this new drug, coinciding with the views of other physicians who have observed its action, is that it is an effective therapeutic agent whose clinical application deserves further study. It may prove to be an indispensable natural form of therapy in cases of primary deficiency of the testes. In other disorders having a psychic or constitutional origin, where the testes are either secondarily or only apparently involved, the results may be harmful or ineffective.

This drug is now being sold in many drug-stores, where it can be purchased without a prescription by any one. At present the cost of this material (\$7.00 to \$10.00 per week of treatment) and the lack of public knowledge of its action temporarily serve to prevent its unsuitable exploitation. New and cheaper methods for its synthesis will probably be developed in the near future, and this event together with the laity's knowledge of its psychic, emotional, and physical effects may bring about the necessity for control of the sale of this drug.

The principles of therapy with testosterone are not sufficiently well established at present to recommend its use by the physician in general practice. For a time, at least, it should continue to be studied in the clinic where are available the guidance of physicians who have had experimental and clinical experience with the endocrine glands and the advice of a psychiatrist whose aid may be needed to solve the many psychic problems which confront these patients.

The author gratefully acknowledges his indebtedness to Dr. R. C. Mautner and the Ciba Pharmaceutical Products, Inc., Summit, New Jersey, for the supply of testosterone (Perandren).

## ART TELLS HISTORY OF AMERICAN MEDICINE



"Beaumont and St. Martin" is the first of six large paintings in oil memorializing "Pioneers of American Medicine" which artist Dean Cornwell will complete in the next few years. Others in the series are: Dr. Oliver Wendell Holmes, Dr. Ephraim McDowell, Dr. Crawford W. Long, Dr. William T. G. Morton, and Major Walter Reed, and one woman, Dorothea Lynde Dix who, while not a physician, stimulated physicians to study insanity and feeble-mindedness.

Arrangements to supply physicians with free, full color reproductions of "Beaumont and St. Martin" without advertising, and suitable for framing, have been made with the owners, John Wyeth & Brother, 1118 Washington Street, Philadelphia.

—☆☆—

## NEOPRONTOSIL IN CHRONIC ULCERATIVE COLITIS

The marked clinical response reported following oral administration of neoprontosil in the treatment of chronic ulcerative colitis is stimulating and it is safe to say that this drug deserves clinical application in an effort to evaluate its efficiency.—*Minn. Med.*, Dec. 1938.

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(SEE PAGE 2.)



# What Should Be the Position of the Medical Profession in the Modern State?\*

DANIEL P. GRIFFIN, M.D.

Bridgeport, Conn.

In this discussion I shall omit any consideration of the nature of the state and of the principles governing the organization of society. However fascinating these excursions might prove to be, we must begin with the practical assumption that we are living under a capitalistic regime, that physicians as a class have definite privileges and responsibilities not only to the state but to patients, hospitals and other physicians and that radical changes in many features of modern life justify and even necessitate a re-examination of these relationships.

What should be the position of the medical profession in the modern state? The question implies a problem — it suggests that there may be more than one solution. Indeed, everyone who has examined the matter knows that there are many opinions and no one of them is free from imperfections.

The old family doctor is now practically extinct. The amazing development of knowledge in every field of medicine necessitating an expansion of the medical curriculum, the necessity of special training for the medical student in preparing for the practice of a specialty, the development of the accessory sciences of dentistry, psychology, sociology and nursing — all these have contributed to the disappearance of the family doctor.

The doctor knows, of course, that a large number of people in the community receive inadequate medical care. Some of these people are well to do but relatively indifferent about their health or the habits on which it depends. Some of them are comfortably off financially but do not believe in drugs or doctors.

At the other end of the scale are the poor who are reached more or less effectively in the hospital wards or the public clinics. I say more or less effectively and I do not know any way to

describe this more accurately. They should be better cared for, but medical attention is generally but one of their pressing needs. They are poor and often their poverty is due to ignorance. Often they are those who have been born with mediocre intellectual equipments and because of this handicap they have always existed at the sub-standard economic level. The doctor isn't to blame for this though he is made the whipping boy in some of the current literature which bears on this subject.

Some of these patients are poor, not because they lack intelligence but because they lack character. Because they are slaves to debasing habits or because they are chronically dependent upon their fellows for the necessities of life. They are tramps, loafers, petty criminals, etc. Doctors are not responsible for their existence either.

A third group is poor because of misfortune. Labor troubles, technological unemployment, illness, accidents and misfortunes of various types have depleted their resources and they are left stranded and dependent.

All of these groups get some medical attention. No doubt, it is often less than they should receive but there are other things which they need too — better clothes, better food, more heat, and light in their homes and relief from the heartbreaking and soul crushing consciousness of being regarded as paupers. It is too much to expect the doctor to remedy all these deficiencies and to correct all these maladjustments.

It is often said, half humorously, that those at either end of the economic scale are well provided for; the rich can have what they need in the way of medical care, just as they can have whatever else is purchasable. The poor, too, are generally well enough cared for by an indulgent government or private philanthropy, so far as their medical needs are concerned.

\*Abstract of a paper read before the Stratford Community Forum, February 15, 1938.

But the problem of the great middle class is unique. They have a little money and so cannot be, and do not wish to be considered paupers. When they need medical care they want the best available. For a brief illness or a minor operation, they are well prepared. When sickness lasts a long time or a serious operation must be paid for, with additional charges for hospital and nursing care, they are often promptly and seriously involved. The high class tradesman or artisan wants his wife to have a private room. This means that he is expected to pay his surgeon his regular fee. It means in many cases that the services of a private nurse are indicated at least on a part time basis. But the expense of these special attentions may be overwhelming and he may come to feel that the life of his dear one is being jeopardized by the mere fact that he is economically unable to provide for her the best type of individual attention throughout this emergency.

There is a well developed and entirely justified resentment against the existence of such conditions. The medical profession is constantly being told that it must do something about them. Everyone admits that the sum total of usable medical and surgical knowledge has vastly increased; many feel that the application of this knowledge to the problems of those most in need of it has been disturbed or delayed by economic factors which should play a much less important part in the problem.

It is precisely on this account that the profession has found itself perplexed; rather tardily perhaps, it has come to recognize the existence of a subject known as Medical Economics. Rather clumsily, perhaps, we have come to grips with the problems which it embraces. Rather reluctantly we have been obliged to relinquish our faith in any of the plans offered as a cure-all for the economic evils which have become attached to the practise of medicine in recent years.

Today's young doctor finds himself entering a changing world. It is also a world which *has* changed very definitely, so far as the promise of economic security to him is concerned. In the first place, he has fewer patients. The birth rate has decreased strikingly even in the past decade and a further sensational reduction is predicted by competent actuaries. Emigration is practi-

cally at a standstill so another potential source of increased practise has been practically abolished.

Yet, if the number of physicians in proportion to the general population remained unaltered, one might say that the problem of making a living should not be an unusually difficult one. When we study the figures, however, we find that the number of physicians graduated by good schools each year exceeds the number retired by death or disability by nearly 1900. In other words, almost 1900 young men and women in excess of the number presumably presently required, find themselves competing for an opportunity to treat the sick or preserve the health of those who are free from illness.

To further complicate the purely economic aspects of the situation, the young graduate finds that certain sources of revenue open to his father are closed to him. Some reference to this has been made in our discussion of the improvement in public health already achieved by the application of new principles or remedies to the cure or prophylaxis of disease. Less malaria, less typhoid, infinitely less smallpox, almost no diphtheria. An increasingly large number of those ill with mental disease or tuberculosis are now cared for in government institutions. Unusual opportunities are also offered for the treatment of veterans in government hospitals though their illnesses may have had no connection with their military service.

Fewer babies are born and of these, fewer are born at home. Thousands of mothers of the class which were formerly confined at home and paid the doctor something, now go to the hospital and pay him nothing. The same is true of many medical and surgical conditions.

This is not a complaint. It is a recital. It indicates however inadequately, the conditions confronting the young graduate in medicine. It has been said that if all of the public received adequate medical care, there would still be an insufficient number of physicians to supply the demand. It is difficult to confute such a statement since the definition of adequate medical care must remain a somewhat vague and changeable one. It is fair to state, however, that in the case of European nations which regulate by law the number of medical students allowed to matriculate each year — basing this number on the probable needs of the existing population, the



proportionate number of medical men is smaller than obtains in the United States.

Assuming that we need as many or more doctors than we have, the problem of providing them with decent incomes must be considered. How it may be done without State Aid to the under-privileged, or some type of insurance attractive to the middle class, or both, is not immediately apparent. Serious objections to each of these methods of meeting the problem have been voiced by competent authorities.

It is fair to say that a very large number of physicians, certainly much more than a majority of them, heartily dislike and sincerely dread the thought of State Medicine. In many instances it appears to them a remote but inevitable termination of some current trend of thought. All of us who are opposed to it perceive therein the inevitable domination of medicine by politics and the subjugation of science by sentiment unless this tendency is arrested.

It may be worth while to consider briefly a few of the widely held but quite divergent viewpoints which have developed about this general theme. One is the attitude of what may be called rugged individualism. Those who hold this view believe that medical service, like any other commodity, is a saleable article; that those who have the price can have the best, those less fortunate may obtain a medium grade of service and that the poor are entitled to what they may get in the free services of the hospitals and clinics.

It is felt that while one may regret that everyone does not get the best in medical care, neither does everyone get the best in housing, clothing or transportation and that the doctor's duty ends when he contributes a fair share of his time without pay to the care of the economically unfortunate.

At the other extreme is a group whose members insist that the nation's health is its most important asset. That health is purchasable but that it is absurd to make the possession of money a condition for its acquisition or preservation. They point out that a nation cannot well exist half well and half sick and they insist that the economic interests of the group which supplies medical care must not be allowed to interfere with the broadest extension of that care to those who are in need.

In between these groups is, quite naturally, a

third one which takes a middle of the road position. These persons feel that something needs to be done; indeed, they have felt so for a number of years. Not only have they felt that something was needed, but they have studiously sought for a solution of the difficulties to which I have referred. The American Medical Association, as a group, and thousands of its members individually, have given a greater or lesser portion of their time to a discussion of these problems. No perfect answer has yet evolved but substantial progress is being made.

At this point I consider it desirable to give some consideration to the structure of our national organization. What is the American Medical Association? In some quarters it is visualized as a group composed of, or dominated by selfish or even sinister medical politicians intent on maintaining at all costs, the status quo in medical practise and using its almost monopolistic control over health and illness without regard for anyone outside its membership.

Certain facts may be cited to correct these impressions. In the first place some kind of organization is essential for the effective coordination of medical effort. We have some 160,000 members scattered all over the world. Their individual interests may include anything from anthropology to zoology but they are all alive and alert to the problems of health and disease.

Their organization is purely democratic. Any member may aspire to the Presidency. No single group, from any specialty or from any section dictates its policies. Membership dues are trifling and no penalty attaches to non-membership.

Its functions are numerous. It aims to maintain and improve the standards of medical, surgical and hospital practise. It publishes a weekly journal which probably has no superior in its class anywhere in the world.

Through one council it expresses its judgments on questions relating to medical education, through another, its opinion on matters of drug therapy. One such group examines food products on sale to the general public; another is concerned with physical therapy methods and apparatus. The misbranding and adulteration of foods or drugs, the practise of quackery within or outside its membership, the false and misleading advertisements so frequently encoun-



tered even in high class magazines are other objects of its earnest attention.

It publishes a monthly magazine for the laity called "Hygeia" in which matters of general interest in the field of health are simply and plainly discussed by authorities who know how to write.

It publishes, yearly, a directory of physicians, hospitals and sanatoria throughout the United States and Canada, giving concise and dependable data about every physician who will take the trouble to register.

Its policies are formulated by its delegates and administered by its Board of Trustees, all of whom hold office through popular vote of the membership. It may thus be seen that some conceptions of its practises are erroneous and unfair.

The Association is often accused of being conservative and this is probably true. By tradition and training its members have learned to tread cautiously on new ground and to examine claims and counter claims with some restraint. Its judgments are not infallible nor are they unchanging. It has at different times expressed different opinions on the value of alcohol. Personally, I am proud of it for having done so, though I may have disagreed with one or both of these pronouncements.

Possibly it has been over-cautious, possibly there are too few young men in its inner councils, possibly its views on some social questions of medical interest or medical questions of social interest are somewhat oblique at times. Certainly some four hundred thirty members expressed such an opinion in the public prints last year.

It is felt in some quarters that as a group we have been too critical and that plan after plan for improving the extension of medical practise has been rejected because it was something less than perfect. Let us examine some of the reasons for which an individual scheme was looked upon with disfavor.

(1) Because it was economically unsound. Plans have been made of which no actuary could approve and which were known to be foredoomed to failure.

(2) Plans have been offered which would destroy or impair the patient and physician relationship. It is felt that this relationship is very frequently an important element in the pa-

tient's recovery and that regimented medicine, however theoretically efficient, has serious handicaps which ought, so far as possible, to be avoided.

(3) Some plans have been rejected because they involved administration by a third party who planned to absorb the lion's share of the funds provided as a reward for his administrative efforts. We have felt that neither the patient nor the physician should be required to contribute a disproportionate amount for the management of any such plan. These comments apply to some of the suggestions for voluntary health insurance.

(4) To meet this objection it has been proposed that such a voluntary health plan be administered by the state. However, it has been regularly found that such voluntary plans inevitably become compulsory ones and that the individual is required and the physician obliged to cooperate in a scheme which often suits neither of them.

(5) Some plans have been rejected because the physician's recompense was obviously inadequate to provide thoughtful and adequate care. Just as it has been found that business does not prosper when low wages are paid, so it is found that medical service is inadequate under a panel system which makes it desirable to see the greatest possible number of patients in a given time. A local chiropractor once boasted of treating one hundred and eighty patients in one day.

(6) Some plans have been questioned because they were applicable only to small areas. It is now widely thought that this should not be an insuperable objection and that, as a matter of fact, the problem, at least in some of its aspects, should be considered a local one.

Quite recently, therefore, the Trustees of the American Medical Association have given additional encouragement and official approval of such an approach and it is felt that it will be possible to demonstrate definite progress in a reasonable time. Certainly many of the best minds in the profession are giving earnest thought to the practical solution of the question.

We return then, after this attempt to evaluate the factors involved, to a consideration of the question proposed to us; "What should be the position of the medical profession in the modern state?" First, and naturally, it should continue

its position of leadership in matters concerning the health of the people. This leadership should not depend on the arbitrary assumption of precedence but should be kept because it has been and will continue to be deserved. It has been said that power is always acquired through service and sacrificed through abuse. With respect for this principle, the continuation of its leadership in matters of health and illness will not be seriously questioned.

Second, the profession should be free. Free from the deadly incubus of regimentation. Free from the crippling handicap of political domination. Free from the need of turning a profession into a trade as a result of economic pressure.

Third, the position of the profession, economically, should be more exactly defined. While I believe that those whose means permit them to do so, should pay more for medical service than those who are economically less fortunate, it should be unnecessary to defend this practice by pointing to the burden of work which the physician does without compensation. Those who can afford to pay directly for his services should do so. Those who cannot, should not be pauperized nor should the physician be allowed to regard himself as a martyr.

Free clinics and free hospital services should be abolished. They are likely to give the doctor a superiority complex and are certain to develop inferiority feelings in the minds of many patients. If the patient is paying something for his care, his self-respect is preserved and his morale improved. If the doctor receives some recompense his staff position develops some tangible value and its duties cease to be charitable chores. Nearly all of us in and out of the profession need to radically revise our notions of charity. We need to remind ourselves that our own prosperity is largely a matter of luck and that the unfortunate applicant for our consideration is our brother under the skin. Either he is undeserving of our help, in which case he should be allowed to help himself, or he is deserving of it, in which case it should be given generously and graciously.

Finally, the position of the profession should be harmonized with that of other groups engaged in raising the standard of living and increasing the sum total of human happiness. We have always been concerned with the problem of pre-

serving and improving the nation's health by direct action—that is, by the treatment of disease and the institution of methods for its prevention. But the problems have grown more complex and we cannot solve all of them unaided.

Probably we need to work in closer harmony with other groups concerned with mental hygiene, better playgrounds, a reduction of unnecessary noise, pure food laws, juvenile delinquency, a lowered maternal death rate, the exposure of quacks, the abolition of useless and harmful drugs, the development of a sane attitude toward the problem of alcohol and the conquest of syphilis, at present regarded as public health enemy No. 1.

The profession cannot and will not relax the intensity of its efforts effectively to treat developed disease, but in the modern state where, in theory at least, efficiency is insisted upon, the prophylaxis of disease must naturally come to possess increasing significance. It is easier to prevent tuberculosis than to cure it. It is simpler to avoid a mental breakdown than to restore its victim to sound health again. It is cheaper to escape the deficiency diseases by a rational diet than to correct their ravages once they have become established. We already possess a vast fund of knowledge concerning the way the human body is undermined by enemies from within and without. As a profession, we have gone to the most extraordinary lengths to convey this information to the laity and to enlist their cooperation in a series of public health programs. These efforts will be continued and intensified. The results will be what you, the public, desire them to be. Robert Hutchins, President of the University of Chicago, reminds us that the American public can have whatever type of education it wishes. It has only to demand it and pay for it. To a great extent the same might be said about your health. Individuals, of course, will continue to suffer from various diseases but the average standard of public health can be raised measurably by intelligent cooperation with the counsel offered you as a result of our researches and experience.

As citizens of one of the few remaining democracies we must be content with something less than compulsory measures in the achievement of our ideal. National health is a great



## Sciatic Neuralgia\*

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Sciatica is actually a symptom rather than a disease. The earliest classical description was by Cotugno in 1764. The sciatic nerve is the largest in the body and is made up of branches of the fourth and fifth lumbar and first, second and third sacral nerves. It passes along the posterior wall of the pelvis and passes out of the pelvis through the greater sciatic foramen and then descends deep in the buttock between the greater trochanter of the femur and the tuberosity of the ischium along the back of the thigh to about its lower third, where it divides into two large branches, the tibial and common peroneal nerves. The sciatic nerve supplies nearly the whole of the skin of the leg, the muscles of the back of the thigh and those of the leg and foot.

Very often we see a tendency for pain anywhere in the leg to be referred to as sciatica. For this reason, it might be well to review the characteristic clinical picture. The pain usually starts in the sacral region deep in the buttock and finally extends peripherally always along the posterior aspect of the thigh and leg and the lateral aspect of the foot. It is brought on and increased by pressure, movement and an uncomfortable position. As a rule, walking increases the pain. Scoliosis of the lumbar spine often develops, there being a concavity towards the healthy side. Coughing, sneezing and straining are very apt to excite the pain. The sciatic nerve may be tender to pressure at the fold of the buttock, in the popliteal space or just below the head of the fibula. The spinous process of the fifth lumbar vertebra is often tender to palpation. Straight leg raising is painful. Sensation is not usually impaired although there may be partial loss of sensitivity along the lateral aspect of the leg and foot. The ankle-jerk is diminished or absent and in long standing cases, there is atrophy of the calf muscles. In the great majority of cases, the sciatica pain is uni-

lateral. Bilateral sciatic neuralgia is a much more serious matter from a prognostic standpoint and is usually due to a tumor of the cauda equina or tumors of the spinal column, sacrum and pelvis, of either primary or metastatic type.

Pain referred along the sciatic nerve can arise from a variety of causes. Foci of infection in the teeth, tonsils and prostate should be eliminated. Infections or arthritic changes in the spine, especially at the lumbo-sacral junction and the sacro-iliac joints will be disclosed by X-ray. Purely mechanical disorders such as spondylolisthesis can be visualized and the advent of the laminograph will make roentgenological diagnosis more accurate. The X-ray will show primary or metastatic bone tumors.

In some instances, the sciatic nerve itself may have been injured by a direct blow where it is most superficial at the junction of the buttock and thigh posteriorly, as a result of which scar tissue may be binding the nerve. Neurofibromata may arise along the course of the nerve, and cause pain in the appropriate distribution. Direct pressure from lesions in the pelvis may cause pain in the sciatic distribution. Carcinoma of the uterus, or a pregnant uterus, or a diverticulum of the sigmoid are examples of this. Finally, there are intraspinal conditions such as tumor of the cauda equina, ruptured intervertebral disc, and hypertrophy of the ligamentum flavum.

The majority of patients with sciatic neuralgia make a satisfactory recovery with bed-rest, although there are instances where orthopedic appliances, physiotherapy or caudal injections of saline are of definite supplemental value. Intrathecal alcohol injections are fraught with great danger and should only be attempted in an individual in the last stages of a malignant tumor. Alcohol injection of the nerve itself is also attended with risk because the sciatic nerve is a

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mixed one, and the alcohol produces motor weakness as well as sensory loss.

It is in those cases where conservative treatment has failed and X-rays have not shown any mechanical infectious or arthritic bone changes, that further investigation must be made to determine whether there be some intraspinal pathology, such as a ruptured intervertebral disc. When the amount of protruded disc material is small, we have the characteristic syndrome of sciatic neuralgia which has been described. If this condition is allowed to progress, sufficient encroachment takes place upon the spinal cord so that a paralysis of both legs may develop with an impairment of bladder and rectal control.

During the last few years there has been a good deal written and considerable clinical investigation stimulated by Schmorl's work on the condition of the intervertebral disc as seen at autopsy in unselected cases. The nucleus pulposus is a pulpy mass in the center of the intervertebral disc. He found many instances in which the disc had ruptured either into an adjacent vertebra or posteriorly into the spinal canal. He concluded that they rarely if ever produced clinical symptoms. As early as 1911, however, Goldthwait called attention to cases of spinal nerve and spinal cord compression from ruptured intervertebral discs. Elsberg had referred to those lesions as chondromata, but they are actually derived from the nucleus pulposus. The rupture can occur at any point along the spine, but most frequently in the lumbar and cervical regions. Pain is an early symptom because of pressure on the nerve roots.

In a patient with a ruptured disc, lateral and antero-posterior X-rays of the lumbar spine may often be negative, but may show an unusual straightness due to a loss of the normal anterior curvature of the spine in this region and a narrowing of the intervertebral space usually between the fourth and fifth lumbar or the fifth lumbar and the sacrum. The next step in diagnosis is the lumbar puncture which should be done as low as possible, preferably at the lumbo-

sacral interspace, that is, one space lower than the usual portal of entry. The first 2 cc. of fluid removed should be sent as a separate specimen for determination of the total protein. After careful manometric tests to rule out a spinal fluid block, further fluid is withdrawn for cytologic and serologic tests. The total protein content is usually elevated. The final step in diagnosis is the accurate localization and visualization of the protruding mass by the use of lipiodol in the amount of 4 to 5 cc. Lateral X-rays with the patient in the oblique or prone position are important. The treatment indicated is laminectomy with removal of the extruded tissue. In individuals engaged in hard physical labor, it is probably advisable to fuse the spine as a final stage in the operation. The operative results are excellent and the operation entails very little risk.

Hypertrophy of the ligamentum flavum with compression of the cauda equina was first described by Elsberg in 1913. The ligamentum flavum is normally composed of yellow elastic tissue and connects the laminae of contiguous vertebrae and lies outside the dura. At times, it may undergo hyperplasia and become greatly increased in thickness, thereby causing compression of nerve roots or the cord. The exact cause is not known, but it has been suggested that it may be due to localized extradural hemorrhage producing fibrosis and thickening of the ligament. When this change occurs around the fourth and fifth lumbar vertebrae, sciatic neuralgia may result as in the case of the ruptured disc. The most common history from the patient is, "while lifting a heavy weight in a bended position I felt a sudden severe pain in the lower part of the back as if something snapped." The finding of a partial or total spinal fluid block, increased total protein in the spinal fluid, and an hour-glass type of filling defect in the lumbar region after lipiodol injection is of additional diagnostic aid. The treatment resolves itself into laminectomy with removal of the

*(Continued on Page 104)*

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# Technic, Physiology and Results in the Application of Therapeutic Hyperpyrexia\*†

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The introduction of malaria for the treatment of general paresis in 1918, soon resulted in the recognition of fever as a therapeutic agent. Though the results obtained were much superior to those of other procedures used, objections to this type of therapy soon arose. Among these were:

1. The super-imposed infection.
2. The mortality rate, as high as 20% in some clinics.
3. The inability to raise and maintain the body temperature at desired levels.
4. The difficulty in controlling the therapeutic agent when alarming symptoms occurred.
5. The difficulty in many regions in obtaining malaria for therapeutic purposes.

Numerous attempts were made therefore, to devise other methods of fever induction, more readily available and more easily controlled. Among these were vaccines, chemicals and mechanical methods. The use of vaccines and chemicals for the production of fever was even less successful or desirable than that of malaria.

During the last ten years considerable attention has been paid to the production of therapeutic fever by mechanical means. These methods can be divided roughly into two groups:

1. Those employing external heat.
2. Those employing internal or penetrating heat.

The electric blanket, lamp cabinets, hot baths and Kettering Hypertherm are examples of the first group. In the second group belong those methods utilizing high frequency currents, short wave, diathermy, and the inductotherm.

Various methods for the production of artificial fever have been used at the Boston Psychopathic Hospital during the past seven years. Among these are:

1. Diathermy current.
2. Radiant heat cabinet.
3. The electric blanket.
4. Kettering hypertherm.
5. Inductothermy.

Since we are now using inductothermy exclusively for the production of artificial fever, we shall describe this method only.

The inductotherm generates a high frequency current from 12 to 15 million cycles per second. The current is passed through an insulated flexible coil electrode and creates an alternating magnetic field of the same frequency about the coil. Voltages are induced in any electrically conductive substance placed within the magnetic field, producing eddy currents. When the patient lies within the electromagnetic field the greatest heat will be induced in those tissues of greatest conductivity, that is, tissues that are most vascular. It is not possible to use an inlying electrical recording thermometer because of the inductotherm current. The rectal temperature is taken with the mercury bulb only after the inductotherm current is turned off.

We have combined the inductotherm with the radiant heat cabinet to hasten the rise in body temperature and permit proper insulation for its prolongation. The cabinet is constructed of celotex. Its roof is lined with eight tungsten bulbs of 100 watt capacity. Three water containers are suspended from the roof to hasten the rise in the wet bulb temperature. The cabinet encloses the patient completely except for the head. Sliding glass partitions allow for the necessary manipulations and observations of the patient. Movements are unrestricted and the patient is quite comfortable. Body temperature can be raised to 105° and 106° (R) by this method in 50 to 75 minutes.

\*From the Neurosyphilis Clinic of the Boston Psychopathic Hospital under the direction of Dr. Harry C. Solomon Chief of Therapeutic Research.

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Our procedure is as follows:

The patient lies on a latex hair mattress of about two inches thickness beneath which lies the looped electrode cable. The cabinet and water containers have been pre-heated for  $\frac{1}{2}$  hour. At the onset of treatment the inductotherm is set at its maximum capacity — 100%. At a temperature of 103° F the inductotherm current is turned down to 75% and if the patient is underweight, to 60%. At a body temperature of 104.8° F the inductotherm current and lamps are turned off and the electrical thermometer inserted. The body temperature under these conditions may continue to rise 0.4 to 0.8. The body temperature is then maintained at the desired level by means of the tungsten lamps, 400 watts usually being sufficient, with a dry bulb level of 110° to 112° F and a wet bulb level of 105° to 108° F.

If restlessness is marked or pulse rate high during induction the lamp capacity can be reduced so that the temperature of the surrounding air blanket is lowered. The speed of temperature rise will therefore be slowed. If the inductotherm capacity is not turned down when body temperature is 103° F but kept at a maximum until the desired temperature level is reached, a continued and rapid rise in body temperature, as much as 2° within 10 minutes may occur with danger to the patient. It is important to remember that the speed of temperature rise increases rapidly as body temperature is raised by this procedure.

We have found this method a very good one. Burns are very infrequent. Body temperature can be maintained not only by means of the cabinet lamps alone, but by the continued use of the inductotherm current at low capacities combined with lower air blanket temperatures. We have preferred the former method so that we may be able to use the electrical recording thermometer during temperature prolongation.

It was soon apparent from our experiences that each method of fever induction possessed its advantages and disadvantages. Methods combining external and internal heating appear preferable to those depending on external heat alone. No matter which method is used, its limitations and dangers should be appreciated. Of greatest importance, however, is a well trained personnel and constant observation since reactions may be alarming and fatal.

An electric fan is allowed the patient in most instances after temperature has reached its desired height and though maintenance of body temperature may be somewhat more difficult, considerable comfort is given the patient. Fluid and salt loss in the sweat are overcome by the ingestion of 0.6% saline solution, the amount of fluid necessary depending on the method of fever induction and duration of treatment.

Fever treatments are given once or twice weekly and in a fasting state to reduce the possibility of vomiting. The patient is examined by the physician before each treatment. To determine the patient's response to the method used the body temperature is raised to 104° F and prolonged for one hour during the first treatment. During the second treatment (for syphilis of the central nervous system) body temperature is prolonged for two hours between 104° and 105° F. In subsequent treatments body temperature is prolonged at the maximum level desired, usually 105°-105.8° for two hours. The total number of treatments will depend upon the disease process treated. Our present procedure is to give 12 to 15 treatments for syphilis of the central nervous system.

But few contra-indications are present for artificial fever therapy. Patients have varied from 6 to 62 years in age. Weak, debilitated or badly undernourished patients are poor risks. Patients with an obviously poor myocardium should not be given artificial fever. Those above 55 years should be watched closely for cardiovascular collapse. Patients with compensated luetic or rheumatic heart disease have also been treated but require considerable watching. The body temperature of these patients should not be raised beyond 105° nor should it be sustained. Treatment should only consist of a rapid rise and fall in body temperature.

Diabetes mellitus is not a contra-indication to artificial fever, the blood sugar showing but slight fluctuations during fever. The diabetic patient is, however, more liable to skin burns which are very slow in healing.

Chronic nephritis, healed pulmonary tuberculosis and cirrhosis of the liver are not contra-indications. Hypertension, unless marked, above 175 mm. mercury, does not militate against fever therapy. It is important that the blood pressure of these patients be watched dur-



ing treatment since infrequently a sudden and marked rise may occur.

Many patients with a systolic blood pressure below 100 mm. have been treated with no untoward effects, but it is wise to obtain frequent blood pressure and pulse readings during the first few treatments to determine the behavior of the cardio-vascular system to the mode of fever induction used, especially when high wet bulb temperatures are present. It must be remembered that there is the occasional patient who, though normal on physical examination, cannot tolerate the high air blanket temperatures present. There are others who can tolerate none of the methods of artificial fever. Treatment should not be given to this group nor should it be attempted with the use of strong sedatives such as morphine, pantopon or amytal. The ability to tolerate high environmental dry and wet bulb temperatures is an individual thing and is not revealed by a patient's basal blood pressure, pulse rate, or body build.

### Physiology

In our work with the various mechanical methods of fever induction it was soon apparent that the comfort of the patient varied considerably depending on the method used. Reactions were more frequent and severe when circulating air of high dry and wet bulb temperatures was used alone, both for the induction and prolongation of body temperature. The use of a combined method permitted lower air temperatures, gave more comfort to the patient and reduced reactions to a minimum. It was our feeling that though the physiological changes in all methods were in the same direction, deviation from the normal was probably most marked in those methods in which fever induction was accompanied by the greatest discomfort to the patient.

We have carried out numerous laboratory and physiological studies during malaria fever, typhoid vaccine and artificial fever. Though it is frequently said that the physiological changes which occur during "natural fever" are similar to those which occur during fever induced by mechanical means, we have found the changes in the latter to be more marked, depending considerably on the method of fever induction used.

### Cardio-Vascular System

**The Pulse Rate:** The increase in pulse rate

during artificial fever differs with each patient and on different treatment days. The pulse rate is considerably influenced by the surrounding air blanket temperatures. Arrhythmias due to premature beats and auricular fibrillation occasionally occur.

**The Blood Pressure:** The systolic blood pressure may rise or fall slightly during fever induction and tends to fall as body temperature is prolonged. The diastolic blood pressure falls, frequently reaching zero levels as determined by the sphygmomanometer. The pulse pressure increases considerably, indicative of an increased blood flow. In a few patients marked increases in blood pressure, even to 300 mm. have been noted.

**The Velocity of Blood Flow:** The velocity of blood flow as measured by the sodium cyanide and decholin method is increased as body temperature rises. The increase may be as much as 300% and is greater when body temperature rises than when it falls. The circulation time fluctuates considerably, as much as 8 seconds, even when body temperature is maintained at fairly constant levels. This is due among other things to variations in the venous pressure, pulse rate, metabolic rate, plasma volume and area of the vascular bed.

**The Venous Pressure:** The venous pressure shows fluctuations in both directions as body temperature rises, most often a rise. When intravenous infusions are given during treatment, a too rapid inflow may result in a marked increase in the venous pressure with symptoms of pulmonary edema.

**Blood Volume:** Reduction in the blood plasma volume has been found on all occasions when fever was induced by mechanical means. The reduction was most marked when fever was induced by circulating hot moist air as in the hypertherm, ranging from 15% to 35%. When fever was induced by high frequency currents alone, or in combination with the lamp cabinet (stagnant air) loss in plasma volume ranged from 10% to 20%.

The reduction in blood plasma volume is of considerable importance since shock symptoms have occurred with a concentration of 20% or more at body temperatures of 106° F or above. The body temperature is also of significance since an equal degree of plasma concentration at

lower temperature levels does not result in shock. The loss in body weight during treatment is not indicative of the degree of plasma concentration or dehydration since gastro-intestinal absorption is delayed or interfered with during fever, the ingested fluids probably remaining in the gastro-intestinal tract. This has been verified by observations that an equal amount of fluid given intravenously will result in much less concentration of the blood plasma volume.

**Metabolic Rate:** The increase in metabolic rate during artificial fever varies from 5% to 14% for each degree of temperature rise. There are marked variations in different patients on different treatment days, restlessness playing a great part. The increase in metabolic rate is greater as the body temperature rises than when it falls. Though body temperature may be maintained fairly constant at high levels, marked fluctuations may occur. The rapidity of rise in the body temperature does not play any part in the results obtained.

**Respiration:** As body temperature rises respiration becomes deeper but the rate may show little change and may even be slowed. As body temperature continues to rise and is maintained, marked variations in depth and rate occur, especially if the patient is uncomfortable. The respirations may be rhythmical resembling Cheyne-Stokes breathing with marked periods of apnea, as much as 60 seconds. This may be due to a great extent to the alkalosis which occasionally occurs and possibly to some edema of the brain.

Discomfort to mechanical methods of fever induction is often accompanied by bizarre types of breathing. Morphia and other sedatives may eliminate the discomfort and bizarre breathing but are dangerous since the respiratory centre is already depressed.

We have maintained that the use of morphine and barbituric acid derivatives during fever is dangerous. By putting the patient to sleep it removes an important guide as to the patient's condition. Temperature control is more difficult, sudden and dangerous rises occasionally occurring. The capillary dilating effect of these drugs is added to those of artificial fever and capillary permeability is increased, resulting in further blood concentration and greater susceptibility to shock. Quastel, following observations on the respiration of the brain tissue, has

shown that the toxicity of these drugs is greatly increased when body temperature is raised.

Other changes have been observed in the blood during artificial hyperpyrexia, but in nearly all cases the importance of the blood concentration has been overlooked. The serum proteins are relatively increased but absolutely decreased. The blood sugar tends to fluctuate in both directions, most often increasing. The potassium of the blood reveals slight but inconstant changes. The blood chlorides are reduced, especially if fluid intake is insufficient, intestinal absorption delayed or vomiting present. The  $\text{CO}_2$  content of the blood is reduced because of the hyperpnea resulting in an alkalosis with increases in the p H of the blood, on one occasion as high as 7.64. The red cell count based on hematocrit values may show a slight increase. The white cell count may increase considerably and on one occasion rose to 60,000. The young polynuclear cells increase, the lymphocytes and monocytes diminish. These changes continue even after body temperature has fallen to normal.

The milder reactions as a result of therapeutic fever include restlessness, nausea, vomiting, burns, abdominal distension and occasional muscle cramps. Severe reactions during fever therapy occur at body temperature levels of  $106^\circ\text{F}$  or above, especially when the wet bulb temperature is high, sweating excessive and dehydration marked. Peripheral vascular failure results. There is a rapid increase in the pulse rate, a fall in the systolic blood pressure to low levels, 60 mm. or less, a rise in the diastolic level in an attempt to overcome further vasodilation, a fall in venous pressure from its pre-existing level and a marked reduction in the blood volume. The breathing becomes slow, shallow and with prolonged periods of apnea. Sweating ceases and the skin is hot and dry. The body temperature continues to rise. Coma, convulsions, muscle tremors and twitchings, paralysis and maniacal excitement occur. Death is usually due to respiratory failure.

The pathological picture of fatal cases reveals extensive evidence of increased vascular permeability and marked visceral congestion. Among the findings are cerebral edema; a pressure cone around the medulla; hemorrhagic encephalitis; hemorrhagic pneumonia; edema of the heart, lungs and gastro-intestinal tract; parenchymatous changes in the liver and kidneys



and degenerative changes in the adrenal cortex. The pathological findings are typical of those of the so-called "shock-syndrome" as described by Moon and of heat stroke.

Where severe reactions occur the following procedure is carried out to reduce the hyperpyrexia, increase the blood volume and overcome the alkalosis and hypochloremia.

1. Immediate withdrawal of the patient from the heating chamber. The patient is sprayed with luke warm water and its evaporation hastened by means of electric fans.

2. An intravenous infusion of 700 cc. to 1500 cc. of isotonic saline 0.9% and glucose 5% given with care that the venous pressure is not raised above normal.

3. Inhalations of 5% CO<sup>2</sup> and oxygen.

In a series of 235 patients treated over a period of 7 years but 2 deaths have occurred.

**Results:** The conditions for which patients have been treated over a 7 year period are as follows:

		<i>Patients</i>
I. Syphilis.		
1. General Paresis	102	
a. with optic atrophy	7	
b. with cardio-vascular syphilis	5	
	—	114
2. Tabes Paresis	2	
a. with optic atrophy	1	
b. with cardio-vascular syphilis	1	
	—	4
3. Juvenile Paresis		11
4. Tabes Dorsalis	7	
a. with optic atrophy	6	
b. with visceral crises	10	
c. with neuritic pains	10	
d. with Charcot arthropathy	4	
	—	37
5. Meningo-vascular	9	
a. with optic atrophy	7	
	—	16
6. Interstitial Keratitis		
a. with congenital syphilis	12	
b. *with juvenile paresis	2	
	—	14

\*Included in above series.

7. Acute Iritis	1
8. Spastic Paraplegia	1
9. Periostitis	1
10. "Wassermann fast"	2
II. Multiple Sclerosis	19
III. Chorea	1
IV. Gonorrhea	
a. Urethra (Male)	2
b. Pelvis	4
c. *Arthritis	12
d. Endocarditis	1
	—
	16

\*One patient of this group in group b.

Total patients treated 237

Experience has revealed that best results with fever therapy are obtained in those diseases in which the thermal death point of the organisms lies within the range of temperature which can be tolerated by the human. This is especially true of the gonococcus, and possibly of the meningococcus. There are other conditions such as syphilitic infections where the responsible organism, though not killed by the temperature obtained, is somewhat attenuated and made more vulnerable to chemotherapy. There are other conditions in which the reported beneficial results cannot be explained by the above factors. Among these are chorea, multiple sclerosis, infectious and hypertrophic arthritis, and asthma. It has been reported recently that hyperpyrexia will cure undulant fever though the thermal death time of the organism is much beyond the temperature levels obtained during artificial fever.

**General Paresis:** For four years treatment of general paresis consisted in most cases of a rapid rise in body temperature to 104° F to 105° F and then a rapid fall. Treatment was given three times a week, a course consisting of from 15 to 20 treatments. During the past 2½ years we have attempted to give each patient a total of 50 hours of fever at levels of 105° F - 106° F. In most cases no trypanamide was given during the period of fever therapy but immediately after fever was terminated.

Improvement, if any, is usually seen during the early part of fever treatment. It is our impression that clinical improvement is more rapid when trypanamide is combined with fever, not necessarily to be given during the actual fever treatment.



In 1935, 33 cases of paresis who had received diathermy treatment followed by tryparsamide therapy were reported from our clinic. These patients had been treated from 1931 to 1934. Our results indicated that 8 patients (24.2%) were improved and working, 7 patients (21%) improved but not self-supporting, 4 patients (12%) were improved but hospitalized, 4 patients (12%) were unimproved, and 10 patients (30%) had died.

A rather cursory examination of the total number of cases of paresis treated with artificial fever in our clinic from 1930 to the present reveals the following:

Of 118 patients with general paresis and tabo-paresis the status of 113 is known. The clinical states of these patients is as follows:

9 patients	7.9%	markedly improved
46 patients	40.7%	improved
35 patients	31 %	unimproved
4 patients	3.6%	worse
19 patients	16.8%	dead

In only 10 of the 19 patients who died was death due directly to general paresis.

It is difficult to group our results as was done in 1935, since many patients, though improved and capable of working, are unable to obtain employment under the present economic conditions. The percentage improvement in this larger series of patients is smaller, however, than was obtained in 1935. Though the death rate is also much smaller it must be stressed that in this present series all patients treated up to the present have been included, whereas, in the group reported in 1935 at least one year of observation had followed termination of fever therapy. The incidence of clinical improvement is much below that obtained in 2 other series of patients reported from this clinic, one treated with malaria associated with other forms of therapy, and the second group with tryparsamide (Table 1).

	<i>Artificial Fever</i>	<i>Malaria</i>	<i>Tryparsa- mide</i>
No. of Patients	113	173	81
Period of Observation	1 month to 7 yrs.	3-9 years (1925-34)	3-10 years (1923-33)
Good improvement	7.9%	36.4%	42%
Partial	40.7%	27.1%	29.6%

Unimproved or Worse	34.6%	13.8%	22.2%
Dead	16.8%	22.5%	6.2%

Table I. Clinical Status in Three Types of Therapy for General Paresis

As yet no analysis of the serological results of this group of patients treated with artificial fever has been made. It is apparent that of the three methods of therapy artificial fever ranks last in the clinical results obtained.

**Tabes Dorsalis:** The treatment of tabes dorsalis with artificial fever has concerned itself with the following: (1) An attempt to relieve the neuritic pains and visceral crises, (2) to modify the trophic joint lesions and (3) to slow the progress of the optic nerve lesions.

I. **Neuritic Pains:** Attempts to relieve the severe neuritic pains of tabes by means of therapeutic malaria have not been very successful. In the group of 10 patients treated with artificial fever 1 patient obtained marked relief, 5 were moderately relieved, 3 patients were unimproved and one discontinued treatment. Other observers have reported similar results. It is our impression that high body temperatures are not necessary when relief from pain is the main objective, temperatures of 103° F - 104° F maintained for 2 hours being the rule. A course of treatment consists of 10 to 20 weekly treatments.

II. **Visceral Crises:** In a series of 10 patients with visceral crises only two patients experienced permanent relief as a result of artificial fever. In these the gastric crises were mild and infrequent. Temporary relief occurred in 3 patients but this was only of brief duration. In one patient of this latter group, 40 short diathermy treatments were given for gastric and rectal crises but recurrences were frequent. About one year after fever treatment the crises ceased and have not recurred for 2½ years. Five patients experienced no relief or became worse. Of the 10 patients 8 had received extensive chemotherapy prior to fever and in these spinal fluid examination was negative. On the whole, fever treatment for visceral crises is discouraging.

III. **Charcot Arthropathies:** An attempt was made to alter the progress of the trophic joint lesions in 4 patients. Despite fever, changes are likely to continue and even new joints become involved. We have, however, seen X-ray

evidence of absorption of bony detritus in the involved joints during the course of treatment. In addition reduction in joint swelling has occurred.

**Juvenile Paresis:** In the group of 11 cases of juvenile paresis a period of 6 months to 5 years has elapsed since fever therapy was given. The clinical status of these patients is as follows:

2 patients	18.2%	marked improvement
4 patients	36.4%	improved
3 patients	27.2%	unimproved
2 patients	18.2%	no report

These results do not differ much from those obtained in acquired paresis.

**Meningo-Vascular Syphilis:** Fever therapy is considerably limited in this group of patients since most cases react very well to chemotherapy. Fever is given, however, to those patients in whom response to chemotherapy is slow.

**Optic Atrophy:** We have not observed any real improvement in the visual field as a result of fever therapy. We feel, however, that fever may delay considerably the progress of the atrophy and is worthy of trial. Our results are in agreement with those of most observers.

It should be noted that though fever may offer but little with reference to the optic atrophy it is of considerable benefit in the treatment of neurosyphilis in this group of patients in whom tryparsamide is contra-indicated because of the optic nerve involvement.

**Interstitial Keratitis:** The results in this group are very encouraging. Fever therapy shortens the duration of the disease and prevents severe damage, though residual corneal opacities may occur. After the first or second treatment photophobia disappears and the conjunctivitis is either completely relieved or much improved. In one patient with juvenile paresis the lesions were severe, corneal opacities resulted and vision was practically gone. Though the ophthalmologist felt nothing could be gained by further fever therapy, treatment was continued and 23 treatments, consisting of 100 hours of fever between 105° F and 106.4° were given. The vision improved remarkably and but little scarring resulted.

We have recently combined fever with mapharsan therapy and though the number of patients treated by this method is small, we feel

that the results may be even better than those obtained by fever alone.

In 2 patients with "Wassermann fast" syphilis fever therapy was not successful in reversing the serology.

In one patient a luetic periostitis of the right tibia had been resistant to intensive chemotherapy. A course of fever treatment, 50 hours of fever at a level of 105° F to 106° F, resulted in a complete cure.

**Multiple Sclerosis:** An attempt to evaluate the results of fever therapy in a disease which is characterized by frequent remissions is rather difficult.

Our procedure at the start was to raise body temperature to 105° F and maintain it for 3 to 5 hours. A course of fever consisted of 12 to 15 treatments. We have altered the method of treatment, raising body temperature from 103° F to 104° F and maintaining it for 2 to 3 hours. We feel that in this disease process one should strive for maximum capillary dilatation only, obtained at these temperature levels. Ten to 20 weekly treatments are given. One patient has received 40 treatments.

In our series of 19 cases, 2 were improved, 3 were moderately improved, 8 were unimproved, 3 became worse, and 3 discontinued treatment. The majority of the patients maintain that improvement has occurred and are very reluctant to discontinue treatment. As a rule no objective evidence of this improvement is seen. We have noted, however, some improvement in speech, gait and muscle tremors. Some patients state that the spasticity is relieved but this is only for a few days' duration. Three patients with marked spasticity of the lower extremities became worse and discontinued treatment.

We have been unable to duplicate the very enthusiastic results reported by Weiss in 1935 in a series of 144 cases. Improvement was noted by him in 65% of the cases.

**Sydenham's Chorea:** We have treated but one case of chorea with an excellent result. The consensus of opinion is that fever therapy is of distinct benefit, the movements ceasing rapidly and the duration of the disease shortened. The temperature levels used range from 103.5° F to 107° F and in some clinics treatment is advised every other day during acute stages of the disease. Recurrences, however, have been noted.



## Bromide Intoxication\*

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Bromide intoxication is a serious condition which is encountered not uncommonly in psychiatric practice. Series of cases have been reported from all sections of this country since the attention of American physicians was first called to this condition in 1927 by Wuth<sup>1</sup> of The Johns Hopkins Hospital. The incidence of bromide intoxication in Southern New England was discussed in a report published in 1936<sup>2</sup>. Fifteen cases of severe intoxication have been seen in 1800 consecutive admissions to the psychiatric service of The New Haven Hospital, with two deaths. The condition, therefore, is of considerable clinical importance and needs continued emphasis.

Bromide is one of the most popular sedative drugs, and has been extensively used in the treatment of nervous and mental illnesses. The bromide salts in various combinations are the active agents in numerous widely advertised proprietary preparations, some of which are marketed under misleading names with exaggerated claims for their therapeutic usefulness. The role of bromide is unrestricted, a physician's prescription is not necessary. The pharmacologic action of bromide is poorly understood by many physicians. The danger of intoxication is not generally appreciated. Methods of diagnosis and treatment of intoxication have not been given sufficient emphasis in clinical teaching. The indications and contraindications for the therapeutic use of bromide are not clearly defined in textbooks of medicine.

The sedative action of bromide depends upon its depressing effect on the central nervous system. Undesirable side effects are uncommon but naseau and acneform skin eruptions sometimes are observed. Bromide is readily absorbed from the stomach but is eliminated slowly from the body, tending to displace chloride in the

blood and other body fluids, where it may accumulate to such an extent that a state of intoxication is produced. The kidney excretes chloride in preference to bromide. The administration of large amounts of chloride accelerates the elimination of bromide. It follows that the danger of intoxication is diminished by a generous chloride intake and is exaggerated in state of malnutrition, cachexia, and dehydration, in which the intake of fluids and chlorides may be limited, or the stores of these substances in the body depleted. Impairment of renal function in nephritic and arteriosclerotic conditions increases the risk of intoxication.

The diagnosis of bromide intoxication depends upon the presence of psychiatric or dermatologic symptoms which may be found alone or in combination. It is confirmed by the demonstration of a toxic level of bromide in the blood. The early mental symptoms are an exaggeration of the therapeutic sedative effect: sluggishness of thought, speech and action, with drowsiness. Impairment of consciousness with disorientation and memory defect follow, and in severe intoxication delirium may occur with delusions and vivid visual and auditory hallucinations. Since bromide is usually given for a pre-existing nervous illness, it is necessary to distinguish the mental symptoms of the bromide intoxication from those of the underlying condition. The skin eruption, if it occurs, is indistinguishable in appearance and distribution from acne vulgaris. Severe skin eruptions may occur in the absence of psychosis, while the skin may be normal in the presence of outspoken mental disturbances. This point needs emphasis since some physicians prefer to wait for the appearance of a skin eruption before making a diagnosis of bromide intoxication. Dependence upon the bromide eruption as a diagnostic aid is one of the chief

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reasons why symptomatic psychoses due to bromide go unrecognized.

The test for bromide in the blood may readily be carried out in the physician's office. The blood protein is precipitated by trichloroacetic acid. The mixture is filtered and gold chloride added to the clear filtrate. A reddish brown color develops if bromide is present. The mixture is then compared with a standard in a colorimeter or comparometer.\* A blood bromide level of 250 mgs.% or higher will account for a delirious psychosis in a patient who is in fairly good physical condition.

The treatment of bromide intoxication is simple. Good nursing care is essential. Wet sheet packs and continuous tubs are used as sedatives. Fluids are forced to at least 3000 cc. a day. 8-10 grams of sodium chloride are given a day in addition to the ordinary diet. Severe intoxication will usually be controlled in two to three weeks.

\*Manufactured by The LaMotte Chemical Co., Baltimore, Md.

Bromide should rarely be used in medical practice and never without the continuous supervision of a physician. The drug should not be given for more than a few days at a time unless the blood bromide level is controlled. The administration of bromide is clearly indicated only in the treatment of epileptic patients where phenobarbital alone in adequate dosage has failed to control the seizures. The combination of phenobarbital and bromide is sometimes more effective than either drug used alone. Psychologic treatment, not drugs, is indicated in the treatment of mild tensional conditions and insomnia. If drugs must be used temporarily, barbiturates are more effective than bromide. Bromide has no place in the treatment of depression. Paraldehyde is to be preferred to bromide in the treatment of severe excitement since bromide is ineffective unless dangerously large doses are given. Bromide should be used with caution in cases of arteriosclerosis since delirium

is readily produced if cerebral arteriosclerosis is present. Nephritis is a definite contraindication to the use of the drug. Bromide should not be used in cases of dehydration or severe malnutrition in which the body fluids and chlorides are low. Deficient diet and dehydration play a major role in the development of bromide intoxication. Finally, the patient should be warned against the purchase of bromide in a drugstore without a prescription. In one fatal case treated in the New Haven Hospital, the patient had purchased bromide in pint sized bottles without the knowledge of the family physician and died of intercurrent bronchopneumonia before the intoxication could be controlled.

### Summary

1. Bromide intoxication is a serious but preventable condition.
2. Bromide intoxication is manifested by psychiatric or dermatologic symptoms which may occur alone or together. The diagnosis is confirmed by the demonstration of a toxic concentration of bromide in the blood.
3. The tendency of bromide to displace chloride and to accumulate in the tissues is the decisive factor in the production of intoxication.
4. Dehydration and dietary deficiency are important contributing factors.
5. Treatment of the intoxication depends on the administration of adequate amounts of fluids and chloride.
6. Bromide should be used less frequently in medical practice, and only under continuous medical supervision.
7. The sale of bromide without a physician's prescription should be prohibited.

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## School Health Policies\*

(EDITOR'S NOTE: Several months ago, the State Department of Education invited a group of individuals representing various interests to confer and advise regarding school health problems. This group included representatives from the educational, medical, nursing, public health and dental organizations of the State.

One of the first undertakings was the formulation of a statement of school health policies of which the following is an abstract. Those interested may obtain a copy of the complete report by writing Dr. Charles J. Prohaska, Secretary of the Committee, State Department of Education, Hartford, Connecticut.

The advisory group is anxious to have comments, criticisms and suggestions regarding the policies outlined. It is hoped that physicians throughout the State will review this report carefully and transmit their reactions to Dr. Prohaska.)

This statement of school health policies is planned (1) to delineate the responsibilities of school programs and (2) to relate the school health program to the health programs or activities of other groups. In other words, it is an attempt to outline those things which schools should and should not do in the field of health.

There are many groups who are interested in child health, such as parents, physicians, dentists, teachers, social workers, Boards of Health and Boards of Education. Improved child health will result, however, not from the activities of one such group or organization working independently but from the harmonious working together of all interests.

In this discussion of policies the committee accepts the viewpoint that whereas the school HEALTH EDUCATION program is definitely a responsibility of the Board of Education, the school HEALTH SERVICE program may satisfactorily be administered by either a Board of Education or a Board of Health. Wherever references are made to the obligation of the schools for work in the field of child health, it is assumed that these obligations are to be met regardless of whether the Board of Education or the Board of Health administers the health service part of the program.

### 1. Healthful Environment.

There can be no argument regarding the school's responsibility to provide a healthful environment. Pupils are required to attend school

and the authority to compel attendance carries the responsibility to provide an environment conducive to growth, conducive to learning and conducive to health. This responsibility includes attention to the arrangement of the school program, consideration of the social and emotional tone of the classroom, as well as attention to school sanitation.

### 2. Care of Accidents and Sudden Sickness.

What should the schools do in case of an accident or sudden sickness? The committee believes that every school should have a planned, written program for the care of these cases. It is also of the opinion that the policy to be outlined in such a program should acknowledge school responsibility for (1) giving emergency care, (2) notifying parents, (3) getting sick or injured pupils home, and (4) guiding parents where necessary to sources of further treatment.

### 3. The Schools and Contagious Diseases.

Although responsibility for contagious disease control is placed with Boards of Health, there are specific ways in which schools can help; and it is found that Boards of Health invite and appreciate such cooperation. It is recommended that it be the policy of schools to give full cooperation to Board of Health efforts for the prevention and control of contagious diseases; and that schools develop planned programs which will incorporate responsibility for the following four procedures:

1. Notify the Board of Health of suspected cases of contagious disease.
2. Isolate and then send home as soon as possible pupils who seem sick in any way.
3. Encourage parents to keep sick children at home and away from other children.
4. Stimulate parents' interest in vaccination and diphtheria immunization.

In addition to the above, schools should do all that is possible to encourage diphtheria immunization and smallpox vaccination, and at the high school level should develop a plan for locating tuberculosis among pupils. This case-finding plan and the follow-up of conditions found should be integrated with other community tuberculosis activities and should supplement programs for

\*Abstract by Charles C. Wilson, M.D., Director Physical and Health Education, Board of Education, Hartford, Conn.



the care of those with active tuberculosis and case-finding programs among contacts.

#### **4. A Program of Health Instruction.**

Health has been recognized for many years as an objective of education, probably with a realization of the basic nature of good health as a foundation for "living most and serving best". It is quite likely that school health programs can make their greatest contribution through health instruction. It is believed that school policies should state clearly and firmly the responsibility of schools to instruct pupils about the functioning of the human body, the causes and prevention of disease, and community health programs. This instruction — as is true of all good education — will be concerned with the habits which are formed, the attitudes developed, and the knowledge learned. The promotion of health through education constitutes a distinct challenge to present-day education.

#### **5. Periodic Health Examinations.**

It is suggested that schools assume responsibility for developing a program of periodic examinations of pupils and that this program encourage such examinations by private physicians. In following such a policy, it will be necessary for the schools to provide for large numbers of pupils whose parents cannot or will not arrange for an examination otherwise. Such examinations as are provided by the schools should be planned particularly for giving information which will assist the school in understanding the pupil, in estimating the pupil's ability to progress with his school program and in determining what individual adaptations may be necessary.

The day-by-day observation of pupils by teachers and the referring of those who do not seem well for further examination and possibly treatment is thought by some to be as valuable a health-promoting activity as periodic physical examinations. Such observations — always to be used as a supplementary measure — will frequently detect pupils in need of medical care which need might not be discovered by medical examination. It will be most effective when all teachers are trained to make careful observations of pupils and when all become conscious of their responsibility for the school-time health supervision of pupils.

#### **6. Special Attention to Pupils Needing Medical or Dental Care.**

It should be the policy of the school health program to plan a definite follow-up of significant

conditions revealed by health examinations, significant health observations of teachers or nurses and known cases of sickness which are not receiving proper care.

In the follow-up program there are several principles which the school staff should observe. First, they should not attempt to diagnose a condition nor suggest a possible diagnosis to parents or pupils. Secondly, school staff members should never attempt to select a physician or dentist for individual pupils or families; it is important that each family make its own selection of professional advisers. A family new in the community may obtain the names of qualified professional people from local medical and dental societies. Thirdly, the school staff should advise consultation with the private physician or dentist and suggest free clinics or part-pay clinics only for those unable to afford private care. When parents or pupils are referred to clinics, they should be informed that clinics are only for those unable to pay regular fees and that admittance will depend on the results of an investigation by a medical social worker. By such procedure schools can to a certain extent prevent the misuse of clinics which, if carried too far, will jeopardize the opportunities of needy pupils.

#### **7. Special Education Programs.**

It should be the responsibility of schools to provide special education programs for those handicapped pupils who cannot satisfactorily cope with the regular school program. There are many types of pupils who need to be considered in making these educational adaptations. There are, of course, mentally sub-normal pupils. Then there are those with severe hearing impairment who need lip-reading instruction and those with severe vision impairment who need a sight-saving class. Pupils with damaged hearts may need a restriction of stair-climbing and a limitation of play. Those convalescing from prolonged sickness or operations may need rest periods. It should be the policy of all school health programs to see that adjustments are made to meet the needs and limitations of particular pupils.

#### **8. Supervision and In-Service Training for Teachers.**

Schools should accept responsibility for providing supervision and in-service training for teachers and should place specific responsibility in the hands of some person especially qualified in education and in school health work for coordinating all school health activities and for relating those to community health programs.



# State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

## Trends in Health Education

ELIZABETH C. NICKERSON, B.S., C.P.H.\*

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Connecticut in line with other states is going scientific. People everywhere want to know "Why" as well as "How". This is particularly true in public health work. The adult is not interested in submitting to a health examination until he knows what, if any, benefit will accrue from it. However, he is immediately sold to the idea if he learns that it has possible economic value — if, by the adoption of careful rules of health at middle life, he can avoid some of the diseases of adult life and look forward to a longer life of greater enjoyment and even extension of earning power.

Many mothers used to look forward with dread to the maternal period for fear of loss of their babies at birth, or early in infancy, in spite of the fact that the medical profession could give them good obstetrical services. Mothers are now asking the "How" of childbirth so that they may also take advantage of every opportunity for preserving their own health during the prenatal period as well as safeguarding the health and development of their offspring. Mothers of the past generation often scoff at such meticulous care at this time, citing the fact that they raised their children without it and they turned out to be fairly healthy. Having heard of the high infant and maternal mortality that prevailed in former years, the present generation takes a firm stand on the side of scientific methods knowing that children of the older days pulled through in spite of and not because of the lack of health precautions recognized as necessary today.

Again, people of today are more inclined to scan their daily diet and question whether it is entirely complete according to the accepted standards in nutrition. In the application of

nutrition to the health of their children, they are convinced of the direct relationship between optimum health and growth and the liberal use of the protective foods — milk, butter, fruits and vegetables, eggs and coarse cereals and breads. Because of their desire to learn more about food principles, adults are studying their own diet and many are adopting for themselves these protective foods as shown by the improvement in the business man's daily lunch with milk and salads and entire wheat bread and tomato juice supplanting the heavier meal of meat and rich gravies, fried potatoes and pastry which has prevailed over so many years. One result of introspection as far as diet is concerned is the danger of following false leaders who make use of scientific nutrition research for clever adaptation to commercial products or for quack propaganda which garbles the facts to serve their own purposes.

The time has come when professional people who have access to scientific facts about life and health must learn how to interpret these to the general public so that they may have a better understanding of health measures which are being adopted for the prevention of disease or promotion of health. In public health work, health education of the people through the dissemination of accurate, authentic information based on the accepted scientific research is considered one of the most important vehicles for health progress.

All types of professional health workers, whether physician, dentist, health officer, sanitarian, epidemiologist, public health nurse, nutritionist or dental hygienist, come in contact with people whom they must influence if they

\*Director, Bureau of Public Health Instruction, State Department of Health.

are to accomplish anything along their own line of endeavor. The medical and dental professions are tending toward prevention of disease and promotion of health through active participation in immunization campaigns, keeping the well baby well, sending the child into school with all physical defects corrected, and advising mothers during the prenatal period as well as giving closer supervision during the postnatal and infant period. Here is a fertile field for health education and the medical profession has long recognized the fact that their own efforts are more effective if they can get more complete cooperation through a better understanding of the scientific principles on which they work.

To assist the professions in reaching their professional families or individuals with whom they come in contact, the State Department of Health has many health educational aids. Many of its leaflets on health subjects are in simple language and might effectively find a place on the waiting room table in the physician's office. Many local groups arrange for health speakers and the State Department of Health is constantly appealed to for such aid. For some years the department has studied the question of making these talks effective and have come to the conclusion that pictures add value to the message. So it has developed a film library for use by its staff or to loan to local organizations which have their own equipment.

Should any physician reading this article wish to take advantage of any of the department's health educational services — leaflets, speakers, copies of radio talks, health films or assistance in arranging for a health talk — this may be secured through the Bureau of Public Health Instruction. The "Health Service Bulletin", briefly describing these services, including a complete list of health leaflets suitable for patients or the lay public, is available on request.



#### DIPHThERIA ANTI-TOXIN IN TREATMENT OF HERPES ZOSTER

Walker and Walker in Archives of Ophthalmology, August 1938, report the successful use of diphtheria anti-toxin in the treatment of herpes zoster over a period of twenty years. 5,000 units are administered and repeated in two days, if necessary. The pain and inflammation are reported to subside within 24 hours after the first injection.

#### STUDY OF THE Pelves OF ADOLESCENT CHILDREN

The Yale University School of Medicine and the Children's Bureau of the United States Department of Labor are cooperating in a study of the pelves of adolescent children.

The children to be studied were the subjects of a previous investigation undertaken by the Children's Bureau in New Haven, Conn., during the period 1923-26. This study was made to show whether rickets could be prevented in children in a community by the intensive use of cod-liver oil and sunlight. It was possible to follow a series of 326 infants with more or less regularity for a period of 15 months or longer. The infants were usually examined and started on cod-liver oil and sunbaths during the first month of life. A control series included a group of infants, most of whom were born during the period of the demonstration, who had not received cod-liver oil or sun baths. In 1931-32 a study was made of the teeth of some of these children.

The purpose of the present investigation is to make a roentgenographic study of the pelves of these children to determine the effect of rickets on the shape and size of the pelvis; that is, to compare the findings in the children who developed roentgenographic evidences of rickets under 15 months of age with the findings in the group who showed no roentgenographic evidence of rickets during the same age period.

All the children will receive the following examinations:

1. A physical examination.
2. Certain anthropometric measures and a record of certain secondary sex characteristics.
3. Roentgen pelvimetry according to three well-established techniques — those of Thoms, of Caldwell and Maloy, and of Hodges.
4. A dental examination.

A member of the Roentgenologic Department of the New Haven Hospital will supervise the making of the roentgenograms according to the prescribed techniques.

The joint medical-school committee and the Children's Bureau representative will be responsible for the conduct of the study and for the preparation of a report, which will be a joint publication of the Yale Medical School and the United States Children's Bureau.—*The Child*, Nov. 1938.



# The JOURNAL of The Connecticut State Medical Society

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**MANUSCRIPTS.**— Manuscripts should be type-written, double-spaced, on white paper  $8\frac{1}{2}$  x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

**ILLUSTRATIONS** — Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

**NEWS.**— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

**ADVERTISEMENTS.**— All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

**SUBSCRIPTIONS.**— Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

**REPRINTS.**— Reprints of papers and obituaries may be obtained from the Editor at cost.

## • Editorials •

### GOVERNMENT BY BLACKJACK

"And they were instant with loud voices, requiring that he might be crucified. And the voices of them and the chief priests prevailed. And Pilate gave sentence that it should be as they required."

Words written 2,000 years ago are strangely applicable to the present time. Last December a Government lawyer, one Douglas Maggs, in charge of secret proceedings before a Grand Jury, traveled the country building up a case against the very defendants he was then proceeding to indict and will now try to convict. We agree with Frank Gannett, eminent newspaper editor, that this is "a clear violation of the immemorial secrecy of grand juries, of all standards of honor in government and of the constitutional right of every American citizen to a fair trial".

The American Medical Association was indicted on December 20. Public opinion had been built up throughout the country prior to the indictment through releases to the newspapers by Mr. Thurman Arnold and his "legal bloodhounds". If such a callous disregard of common decency accomplished nothing more it served to poison the public mind and the minds of the prospective grand jurors in the District of Columbia before they were even summoned and sworn to investigate the charges the assistant attorney-general in charge of anti-trust law prosecutions intended to present.

The climax to Mr. Arnold's methods comes in his release of August 1 when he states that if the physicians indicted will agree to do what he says they must he will submit the agreement to the Court and let the Court decide whether the indictment be dismissed and the defendants freed from further prosecution. As expressed by Mr. Gannett, "this is government by blackjack". Thurman Arnold is setting himself up in place of the Congress of the United States and decreeing that the medical profession must do as he says or take its chances with a jury already prejudiced against it. Do we dare harbor the



suggestion of brown or black shirts in high places?

The public press is becoming aroused by such tactics. The medical profession asks no better champion. Similar procedures were attempted against certain automobile finance companies not long ago. Congress leashed the legal bloodhound and tied him up in his kennel. Now he is at large again. It is not something which concerns the doctors alone, the rights of American citizens are at stake. Should the defendants refuse to submit to the arbitrary will of Douglass Maggs and Thurman Arnold and win the case it may prove to be a turning point in American history. Our country must still stand for Liberty, Equality and Justice.

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#### INCLUSIVE HOSPITAL RATES

Originally the day rate charge made by hospitals covered all services rendered, but with the increased use of laboratory facilities, X-ray, electrocardiography and other technical procedures, there arose a necessity to make special charges in addition to the day rate. This has resulted in a confusing patchwork of rates and charges to the patient that are often impossible for him to understand, and difficult to explain. Moreover, the system often penalizes the self-pay patient inasmuch as his physician hesitates to order special services because of the cost. It is not infrequent for the non-paying patient to have better access to these important special services than the paying patient, because his physician is free to order any of them.

To correct this confusing inconsistency, hospitals here and there have instituted inclusive rate methods for making charges. The New Haven Hospital, certain that a hospital should offer in-patients a complete service rather than a group of disconnected services, established an inclusive rate system on January first. The inclusive rate covers room and board, regular nursing service, diagnostic X-ray service, anaesthesia, operating room service, delivery room service, emergency room service, laboratory services, including metabolism and electrocardiography, ambulance within the city area, formula drugs and medicine, oxygen therapy and physical therapy. It does not include private nurses board, radium and X-ray therapy, donors fees, special drugs, home-going supplies and orthopedic appliances.

There are sure advantages for the attending physician in this new rate structure, for under it he is able to employ many diagnostic and treatment procedures that might otherwise be dispensed with, in an effort to save his patient expense. To the patient there is the advantage of being able to estimate with fine accuracy just what his hospital charges will be for any expected stay. The experience of the New Haven Hospital with this plan will be watched with interest.

C.B.

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#### THE DOCTOR OPENS AN OFFICE

Following the custom of generations, the young physician on arrival in the town of his choice circularizes the profession of that locality with an announcement card setting forth the purpose of his life work, his hours of availability and the location of his office. The less conventional may write personal notes to friends in the profession; the more daring and perhaps less ethical, though ethics in New England and in the Texan Panhandle may vary markedly, have managed to find their announcements properly illustrated in the daily press.

To assist the neophyte in his ethical dilemma as well as the better known practitioner when he changes his headquarters from one city block to another, the Journal proposes to maintain a column for such announcements. Some of the profession today are confining their activities to certain limited fields in compliance with the standards set up by the various specialty certifying boards. Announcements of such changes in practice will be included in this proposed column. It is hoped that the Journal, by so doing, may render a dignified service to the profession of Connecticut, at the same time assuming no responsibility for these announcements other than to establish in good faith the identity of the physician submitting the announcement.

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#### JOURNAL ADVERTISING PAYS — YOUR PATRONAGE IS THE ANSWER

With the advent of this New Year our readers were introduced through the columns of the Journal, to over a dozen new advertisers. With this second issue of 1939 we are proud and happy to add several more newcomers to our advertising columns. In a few instances we have been sought out as a growing publication worthy

of consideration but the larger number of our new advertisers have been secured through repeated and relentless effort. We take credit for some of this expansion and with gratefulness we acknowledge the invaluable assistance of the Cooperative Medical Advertising Bureau of the American Medical Association.

Advertising in the Journal of the Connecticut State Medical Society should pay and will pay under one condition only, that our readers give their patronage to those who are using our advertising columns. The pages of our Journal are not available for unapproved products and because of our standards not every advertiser who has requested space since our first issue two and one-half years ago has been granted the privilege. Business prospects for 1939 are encouraging, the Journal is growing in prestige and we have potential purchasing power sufficient to satisfy even the most exacting advertiser.

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### OUR FAME SPREADS

The October issue of Connecticut Bar Journal contains an article entitled, "Physicians and Lawyers," by George H. Cohen of Hartford, reprinted from our September issue. "Connecticut Obstetrical Consulting Service", by Joseph H. Howard, M.D., Bridgeport, was reprinted in full in "The Child", for November, 1938. The editor of the Journal of the Indiana State Medical Association in the December issue quotes extensively from "The Traffic in Drugs", by Theodore G. Klumpp, M.D., appearing in the October issue of the Journal of the Connecticut State Medical Society.

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### WRITE YOUR CONGRESSMAN IMMEDIATELY

We can assure our hypothetical doctor, who is interested in a public question, that he will not be regarded as a meddler when he writes his Senator and Congressman, especially if he makes clear, briefly, the reasons for his approval or disapproval of legislation. He may also go a step farther and explain the nature of a law to others so that they, too, in their own language, may register their views. He is the man, at long last, who will be called upon to deliver the medical care which is the subject matter of proposed legislation, and if he knows good reasons why certain laws will work, and others will not, he may properly see to it that they are presented

to the men who make our laws. In fact, it may even be that his Senator and Congressman are waiting to hear from him.—*Pub. Opin. Quart.*, Jan. 1939.

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### THE FARMER SPEAKS

In an editorial in *American Agriculturist* for November 5, 1938, we find the following:—

Let the State continue and even extend its public health work to *educate* and *guard* people in the field of *preventive* medicine.

Arrange for that part of the population which is clearly unable to pay doctors' and dentists' fees to be taken care of by local authorities or possibly by representatives of the State Health Department, never by distant Federal authorities. Under this plan the doctor would not have to do too much charity work nor overcharge his paying patients.

Leave the rest of us alone to run our lives, choose our own physician and pay him a reasonable fee. Then we can continue to stand on our feet, keep our self-respect, and maintain the splendid and helpful relationships that have existed in the past between the doctor and his patient.

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### CALIFORNIA APPROVES PLAN FOR MEDICAL CARE

At a special meeting of the House of Delegates of the California Medical Association in Los Angeles, December 17 a plan to provide medical care to residents of the state at a cost of about \$2.50 a month was approved, *The Journal of the American Medical Association* for December 24 reports.

According to the *New York Times*, patients will select their own doctors and hospitals. Payments will be made on a weekly, monthly or semi-monthly basis. Physicians will be paid on a unit basis, the payments graded from single units for minor services to twenty-five or more units for major operations. It is expected to take about six or eight months to put the plan into operation. While the exact cost has not been determined, the estimate is \$2.50 a month for each person. No provision for family group insurance was made under the revised final plan. Hospital, medical and surgical attention will be provided and the expense may be lower if 500,000 or more persons participate in the plan.



# From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street

New Haven

## COMMITTEE ON PUBLIC HEALTH

The Society's Committee on Public Health met on December 15th. There were present: Dr. Joseph H. Howard, Chairman; Dr. Donald A. Bristoll, Dr. Luther K. Musselman, Dr. Oliver L. Stringfield, Dr. Robert M. Yergason, Dr. Francis A. Sutherland, Dr. Howard S. Colwell, Dr. Jessie Fisher, Dr. Martha L. Clifford, and Dr. Creighton Barker.

Among the many subjects discussed at this meeting was delinquency in the filing of birth certificates by members of the Society. Under existing State Law the Health Commissioner is empowered to prosecute physicians who fail to file birth certificates promptly. Thus far there have been no prosecutions, but the Committee was of the opinion that such prosecution should be made of physicians who consistently violate the statute.

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## SECTION PROGRAMS

The Secretary and the Program Committee wish to urge the Chairmen and Secretaries of the various special sections to expedite the arrangement of the programs that will be presented during the Annual Meeting in May. In order to be published in the May Journal these programs must be in the Secretary's office not later than April 10th.

## COMMERCIAL EXHIBIT AT THE ANNUAL MEETING

Mr. Thomas R. Gardiner of New York, who for the past two years has directed the commercial exhibit in connection with the Annual Meeting of the Society, is unable to be with us in 1939, because of pressure of personal affairs, and the 1939 exhibit will be managed through the Secretary's office under the direction of Dr. John H. Bumstead.

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## SECTION ON INDUSTRIAL HYGIENE

The Society's Committee on Industrial Health has suggested that a Section on Industrial Hygiene be formed in the Society. The object of this section will be to bring together physicians who are concerned with the health hazards in industry. Those interested are invited to communicate with Dr. Clifford Kuh, Chairman of the Committee on Industrial Health, 31 Howe Street, New Haven.

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## COMMITTEE ON PUBLIC RELATIONS

The newly constituted Committee on Public Relations, under the Chairmanship of Dr. Stuart H. Bowman of Stamford, had its organization meeting on December 20th. Those present were: Dr. Stuart H. Bowman, Dr. Edmund L. Douglass, Dr. Ralph L. Gilman, Dr. Michael J. Lawlor, Dr. Ella Wilder and Dr. Creighton Barker.

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(SEE PAGE 2.)



## SECTION ON Orthopedic Surgery

### New Book on Fractures

Mr. Watson-Jones of Liverpool, England, will soon have his first book on fractures ready for delivery. It is reported to be quite up to date, representing the Liverpool school of fracture treatment. The appearance of this volume now has compelled Mr. McMurray to withhold his expected book on fractures until a later date.

### Traction Splints

The Hand Book of the Boy Scouts of America has recently been revised to include first aid instructions referable to the application of a Thomas splint. Incidentally it is very well phrased and should prove of considerable value in promoting better care for early fractures. The splints are now recommended as part of the first aid equipment of a scout patrol. How many physicians carry these splints in their car? They occupy almost no room and might save a life. *Why not order a set today?*

### Son Succeeds Father in Orthopedic Department

Dr. Joseph A. Freiberg, associate professor of orthopedic surgery, will succeed his father, Dr. Albert H. Freiberg, as head of the department of orthopedic surgery of the University of Cincinnati College of Medicine. The elder Dr. Freiberg resigned in July after forty years of service. Since then his son has been acting head.

### Sarcomas of Muscles and Intermuscular Septum

Recently at the French Surgical Congress, meeting in Paris, sarcomas of the muscles and intermuscular septums of the extremities were discussed. One hundred and nineteen personally observed cases showed 43 in the intermuscular fibrous tissues and 37 within the muscles. Those within the muscles were encapsulated and easily enucleated. The capsule, however, was so thin

that invasion of the adjacent tissues was frequently observed, thus recurrences were often noted. Involvement of lymph-nodes was reported as quite rare. Sarcomas of the muscles were also encapsulated with these capsules equally thin giving rise to recurrences following removal.

A second type of muscular sarcoma was reported which was limited to a particular muscle. Hence its removal would result in a cure following a single excision. The prognosis in general was reported as unfavorable with only fifteen apparent three-year cures in 119 cases. The duration of life without operation was noted as two to three years. Surgery was advocated.

### Ascorbic Acid in Healing of Fractures

An Italian surgeon recently reported halving the time of fracture healing in cases using ascorbic acid intramuscularly. The day the fracture was reduced and immobilized, .005 grams of ascorbic acid was injected into a muscle. Thereafter every three days .001 grams were administered in the same manner until fracture healing took place. X-ray control showed to his satisfaction that fracture healing took place in just one half the time in these cases reported. He used a series of fractures reduced and immobilized without the use ascorbic acid as a control. This work might be verified through other experimental work in the interest of economy. If fractures can be made to heal in half the length of time that it now takes, a great saving will take place.

### The American Rheumatism Association

Soon there will be ready for distribution reprints of the proceedings of the fifth annual meeting on rheumatic diseases which was held in San Francisco, June 13, 1938. These may be obtained from Loring T. Swaim, Secretary, Boston, Massachusetts. From the papers reported and the discussions listed in the Journal of the American Medical Association, this report should be most enlightening. It will bring up to date the problem of rheumatism as far as the American Association can accomplish this purpose.

## Our Neighbors

### MAINE

R. W. Belknap, M.D., of Damariscotta, Maine, reports a case of gunshot wound of the pregnant uterus in the Maine Medical Journal for January, 1939. The wound was self-inflicted and in perforating the uterus penetrated the left chest of the foetus just below the clavicle. A Porro Caesarian operation was done, a dead foetus delivered, followed by recovery of the patient after a stormy convalescence.



### MASSACHUSETTS

Organization of hospital centers for premature infants in Massachusetts has now been completed and the total number is 48. Incubators are not provided for the transportation of premature infants, either by law or otherwise. The hospital centers have supplied themselves with carrying baskets heated by hot water bottles. Several public health nursing organizations have supplied themselves with a similar basket or box. These are available to anyone in the community who needs them.



### NEW JERSEY

Governor Moore of New Jersey called a general conference of leaders of health and welfare workers in that state at Trenton in November. The President of Rutgers University was chosen permanent chairman and there were present representatives from the State Department of Health, the State Department of Institutions and Agencies, the Medical Society of New Jersey, and their major subdivisions. The immediate occasion for the conference was the National Health program as outlined during the summer in Washington. Governor Moore is asking for advice in meeting the health problems of his

state and is to be congratulated on his wisdom shown in seeking guidance from experts.

Material for the public press in New Jersey is required to be inserted as paid advertising. Medical information must be released by the Public Relations Committee of the State Society to the County Societies for publication in the local papers.



### NEW YORK

A decision was rendered recently by a Brooklyn magistrate which strikes a blow to the practitioners of chiropractic. In New York State this cult is not permitted to practice medicine, diagnose or prescribe drugs. The judge ruled that in signs bearing the legend "doctor" and in the set-up of the office where medical instruments and apparatus are evident there is a "holding out" to practice medicine which is illegal. This is one of the most important rulings handed down on the subject of chiropractic and will materially aid in the prosecution of illegal practitioners.

Dr. Beckett Howorth of the New York Orthopedic Hospital presented the subject, "A Doctor's Opinion of Socialized Medicine", before the Current History Club of Choate School recently. The speaker expressed himself in favor of correcting the mistakes existing in our present system rather than changing the entire system of medical practice.

The recent meeting of the New York State Temporary Commission to Formulate a Health Program disclosed almost complete agreement among the medical men who testified. It was agreed that compulsory health insurance is unnecessary and would jeopardize the standards of medical care.

Important and valuable modifications in both the rates and coverage of the New York State Medical Society's Group Plan of malpractice defense and indemnity have been reported by the Insurance Committee and accepted by the Council. The base rate has been reduced to \$28.00.

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(SEE PAGE 2.)



## - NEWS -

### *from County Associations*

#### Fairfield

The Fairfield State Hospital provided a special program of recreation and entertainment for its patients during the Christmas season. The hospital now has a much needed building program in active operation, with new units under construction which, by 1940, will provide fifteen hundred additional beds and thus afford relief from the present inadequate facilities for the care of the mentally ill in Connecticut.

Greenwich has a Mothers' Milk Station in operation two years this March. Since its opening 97 babies have been fed at the station. Each mother receives a thorough physical examination including a Wassermann test. The milk is collected daily from the mothers in the home and the entire collection is then strained, pooled, bottled and pastuerized. Charges are based on ability to pay up to thirty cents an ounce. Hospital service cases are charged a flat rate of fifteen cents an ounce.



#### Hartford

Several doctors plan to attend the 4th Annual Post-graduate Institute of the Philadelphia County Medical Society to be held from March 13 to 17 at the Bellevue-Stratford Hotel in Philadelphia. The cost of these lectures, numbering almost ninety and given by about the same number of lecturers, is simply the registration fee of five dollars. The Institute this year will be concerned with "Blood Dyscrasias and Metabolic Disorders". These lectures are comprehensive and the attendance is highly recommended to all who can take advantage of this unusual opportunity. Those who attended last year's Institute on "Diseases of the Gastro-Intestinal Tract" recommend the value of these post-graduate reviews.

It is with profound regret that we record the passing of Dr. James Lynch, President of the Staff of St. Francis Hospital in Hartford. While Dr. Lynch had not been in the best of health for the past year, his death on January 7, 1939, was rather sudden and unexpected. Although only

47 years of age, he had matured as a surgeon many years before and for a quarter of a century he rendered able and conscientious service in this County and gave himself to much charitable medical work. His death is veritably a tremendous loss.

The sympathy of the members of the County Association is extended to Dr. Benedict M. Whipple of Bristol whose wife, Bertha Kane Whipple, died recently.

The engagement of Dorothy Brudick Brand of Hartford to Dr. Edward V. Carvey of Wethersfield is announced.



#### Litchfield

The annual meeting of the Maria Seymour Brooker Memorial was held in Torrington on January 16. Frank M. Travis presided. A financial report for the year was made by John M. Wadhams. Re-elected to the board of corporators were Frank Appelt, W. R. Reid and Mrs. Charles Alvord.

Motion pictures illustrating various phases of oxygen therapy were shown at a meeting of the Journal Club of the Charlotte Hungerford Hospital by Mr. Powderly of Boston on January the 12th. This meeting was well attended by members of the medical and nursing staffs.



#### Middlesex

At a special meeting of the Middlesex County Medical Association held in November, the contract for pre-payment hospitalization insurance, as offered by the Plan for Hospital Care, Inc., was approved. The County society joined with the local medical society in offering this service to the members as a group.

The revised by-laws of the Association which were adopted at the semi-annual meeting in October received their final vote of approval.

At the last meeting of the Central Medical Association it was voted to send each member the following message: "Please inform nurses employed at factories to refer patients to their family physician and not to the employer's physician when illness is not due to employment."

At a recent meeting of the Board of Health of Middletown, Dr. M. L. Palmieri, the local health-officer, proposed that steps be taken to obtain legislation which would compel all ex-



pectant mothers to undergo a Wassermann or similar blood test.

The fifth annual meeting of the Connecticut Association of Public Health and Clinical Laboratories was held at the Middlesex Hospital in Middletown on November 17, 1938. Dr. Jessie W. Fisher, retiring president, conducted the meeting. A symposium on "Epidemic Diarrhea of the New-born," was held with Drs. John E. Hetzel, J. O. Collins, Earle K. Borman and A. L. Burgdorf taking part. The newly elected officers of the Association are:

President: Dr. Louise D. Larimore, Greenwich Hospital.

Vice-President: Mrs. Lucille Grimes, Griffin Hospital.

Secretary and Treasurer: Mr. Earle Borman, State Department of Health.

Councilor: Dr. Jessie W. Fisher, Middlesex Hospital.

A reception was held at Bengston-Wood Hall in Middletown on Saturday, December 3, in honor of Mr. Howard S. Pfirman, who assumed his duties on December 1 as the newly appointed superintendent of the Middlesex Hospital.

A joint meeting of the Health Officers of the State and the Connecticut Public Health Association was held at Wesleyan University in Middletown on November 30, 1938. A full day's program had been arranged consisting of a field visit and talks relating to the Administrative Control of Food Handlers and Places Dispensing Food and Drinks, Developments for the Control of Syphilis and Gonorrhea, and Infant and Pre-School Child Health Programs.

At the annual meeting of the Medical Board of the Middlesex Hospital held in January the following officers were elected:

President: Dr. A. N. Sweet.

Vice-President: Dr. H. E. Speight.

Secretary: Dr. C. C. Chase.

Dr. Henry Sherwood who recently completed an internship at the Middlesex Hospital has opened an office on Main Street in Durham.



## New Haven

Four original papers were presented at the December meeting of the Yale Medical Society. Dr. L. C. Strong reported on the chemotherapy of cancer in animals. Studies of the effect of prolonged insulin hypoglycemia on the distribu-

tion of water and electrolytes in the brain were presented by Dr. Herman Yannet, who also collaborated with Dr. H. M. Zimmerman in the third paper of the evening on the histopathological changes in the brain following prolonged insulin hypoglycemia. Dr. R. G. Winzler reported studies on the relation between exidation and synthesis in yeast.

The January meeting of the Yale Medical Society was addressed by Dr. Norman E. Freeman, Ass't. Prof. of Surgery, Harrison Dept. of Surgical Research, University of Pennsylvania School of Medicine, on "The Circulation in Surgical Shock". Dr. Freeman was graduated from the Yale School of Medicine in 1928; after two years internship at the Hospital of the University of Pennsylvania he was awarded a National Research Council fellowship and spent the next two years as medical fellow in physiology at the Harvard Medical School. Following two years as assistant resident surgeon he was appointed resident surgeon at the Massachusetts General Hospital in 1935. In 1936 he remained at Harvard as Dalton research fellow. The following year was spent as senior fellow in the department of research surgery at the University of Pennsylvania Medical School. His appointment as J. William White Ass't. Prof. Surgical Research was made in 1937. Dr. Freeman's productive career in the decade since his graduation from medical school has already fulfilled the high promise that he exhibited as a student and the occasion of his return to address the Yale Medical Society on the clinical interpretations of his original studies was a particularly felicitous one. A gala dinner at the home of Prof. John P. Peters attended by Dr. Freeman's former teachers preceded the meeting.

At its first meeting in December, the New Haven Medical Association admitted the following physicans to membership: Max L. Berlowe, Long Island College of Medicine, '34, New Haven; Joseph J. Bruno, Hahnemann Medical College, '35, New Haven; Joseph N. D'Esopo, McGill University, '31, West Haven; Morris Freedman, Tufts, '32, New Haven; Benjamin R. Gendel, Tulane, '35, New Haven; Samuel D. Kushlan, Yale, '35, New Haven; William S. Perham, U. of Michigan, '32, New Haven; Charles M. Spiegel, Hahnemann Medical College, '36, New Haven; Kenneth Wade Thompson, Harvard, '29, New Haven.

The new members were no less delighted than the old ones to receive the following announcement from the Association's genial secretary: The regular Christmas meeting will be held on Wednesday, December 21, 1938, at 9:00 o'clock sharp. The exercises will consist of the following:

1. Reading of the minutes.
  2. Listening to the minutes by the members.
- This quaint custom is revived once a year for old times sake.

3. Presentation of Cases.

Review of recent deliveries by the New Haven Railroad. Cases of face-to-face presentation in babes over eighteen personally conducted. Carefully selected cases from the Stork Club and other hyperthermic areas of Manhattan. Clean fun without fans. Dr. Edmund Fitzsimons.

4. Paper of the Evening:

A symposium on Deglutition and Digestion. Buffet Supper.

(a) Low calory diets for Succulently Successful Specialists.

(b) High calory diets for

1. Practitioners in poverty.
2. Parsimonious Professors.

—Sir Thomas Semley, Chef.

5. Annual presentation to Entertainment Committee of Avis Bronxii Vulgaris, (the bird), by dissatisfied members.

6. Adjournment.

Dr. W. J. Dennehy, Secretary.

At the regular meeting of the Waterbury Medical Association on November 10, 1938, Dr. George Crile gave a paper on the "Surgical Treatment of Essential Hypertension." Discussion was led by Drs. H. M. Marvin, Ashley Oughterson, and John Leonard of New Haven, and Dr. D. C. Patterson of Bridgeport.

On November 17, 1938 the Public Health Forum conducted by the Waterbury Medical Association was addressed by Dr. Foster Kennedy, professor of neurology at Cornell Medical School, his subject being "Preventive Aspects of Neurological Medicine."

Dr. Arthur Jackson of Waterbury and Mrs. Rodney Chase of the Waterbury Mental Hygiene Society discussed the paper. Many questions were asked by the audience in the question period.

On December 8, 1938 at the regular monthly meeting of the Waterbury Medical Association a paper on "The Management of Coronary Artery Disease" was given by Dr. Louis F. Bishop, Jr., Associate Visiting Physician of Bellevue Hospital in New York City.

The discussion period following this paper showed the subject was one of great interest to all the members.

Dr. Arthur Jackson also presented a case report showing the beneficial results following air insufflation in a case of post-traumatic headache which had persisted for 20 years.

The Grace Hospital of New Haven has recently acquired equipment for roentgen pelvimetry which is now one of the regular services offered by the X-ray department under the direction of Dr. William E. Dobbs. With the addition of Dr. Clement C. Clarke of New Haven to the staff of the Grace Hospital it is planned to develop an Eye department comparable with other special departments at the hospital. The department will be equipped so that all types of eye surgery may be performed in addition to facilities for examination and treatment in the out-patient department and on the wards of the hospital.

The beginning of the new year witnessed a striking change in the system of charges at the New Haven Hospital. An inclusive rate schedule replaces the former system of special charges for diagnostic and technical procedures. The fundamental rate for each type of accommodation on the private and semi-private services is unchanged ranging from five to twelve dollars per day. In any of the private or semi-private accommodations the entire extra charge for ancillary services is distributed over the first week of hospital residence approximately as follows: 1st day, \$8.50; 2nd, \$6.00; 3rd, \$5.50; 4th, \$5.00; 5th, \$3.00; 6th, \$3.00; 7th, \$3.00. After the first week of residence, regardless of length of stay and the extent of use of the laboratory and special facilities, there is no extra charge. The new schedule of charges for ward services is simply a flat rate of \$5.00 per day. Although at first sight this would seem to mean an increase of \$2.00 per day in the charges for ward accommodations, the fact that extra charges to ward patients have heretofore averaged one dollar per



patient per day means an actual increase of only one dollar per day in the cost of hospitalization. A glance at the services included in the new plan indicates the boon which the inclusive rate system provides for the ward patient whose problem requires extensive use of special diagnostic procedures. The rate of \$5.00 per day includes Room and Board, Regular Nursing Service, Diagnostic X-ray Service, Anaesthesia, Operating and Delivery Room, Emergency Room Service, Laboratory Service (including Metabolism and Electrocardiography), Ambulance in city area when authorized, Formulary Drugs and Medicines, Oxygen Therapy and Physical Therapy. These same services are of course available to patients in private and semi-private accommodations according to the inclusive rate schedule.



### New London

At the Tri-City Medical Society meeting on January 12 held at Uncas-on-the-Thames the guest speaker was Dr. A. J. Urquhart who for the past ten years has been practising in the extreme northwest corner of Canada. He is brother of Dr. R. Glen Urquhart, chief surgeon of the Connecticut sanatoria. Dr. Urquhart, who has served as medical officer and administration officer for the Canadian government and who has had jurisdiction over a territory of approximately 90,000 square miles, in the far northwest, gave a very interesting talk on the Eskimos and Indians of that region.

Dr. and Mrs. Urquhart, in August, 1931, entertained Col. and Mrs. Lindbergh when the famed flier and his wife were on a flight to the Orient. The famous couple stopped off at Aklavik and were guests of Dr. and Mrs. Urquhart for five days. Dr. Urquhart's wife was the first woman to fly across the Arctic, making the journey with her husband during their wedding trip. Dr. Urquhart is probably the world's most northern doctor.

"Severe Hyperchromic Macrocytic Anemia of Pregnancy" by Drs. Charles G. Barnum and Joseph C. Woodward appears in the Journal of the A. M. A. for November 5, 1938, under Clinical Notes.

## Letters to the Editor

To the Editor of the Journal:—

I thought this might be worth repeating. It wouldn't be needed if all the members of the Society would try to contribute something to its progress.

### State Medical Societies

State medical societies should be the real executive branch of organized medicine. From them should come the major part of the opposition to the various encroachments upon medical practice and likewise they should materially assist in devising plans for the better distribution of medical services. State medical societies which fail to energetically carry on these two functions, contenting themselves with the election of inactive or inefficient officers, confining their work very largely to the few days of the annual meeting, and offering no definite leadership or taking no definite stand on the vital issues facing the medical profession, are failing in their duty both to the profession and the public. (*Tri-State Med. Jour.*, June, 1938).

Sincerely yours,

Daniel C. Patterson, M.D.



### CONTROLLING THE SIZE OF THE FAMILY

The problem of planned parenthood, of controlling the size of the family and the spacing of the children is one that vitally concerns the health of the mother and the happiness of the family circle. It is a field of preventive medicine that demands our most serious attention in the coming years. Now that both the laity and the profession have brushed aside to a large measure the legal restrictions and mid-Victorian foibles that in the past interfered with a free discussion of this subject, we can fairly hope in the near future to see our country peopled by a greater proportion of happier and healthier mothers with a greater proportion of healthy babies who survive to maturity.—*Taussig, Jour. Ark. Med. Soc.*, Dec. 1938.

## SPECIAL NOTICES

### AMERICAN BOARD OF OPHTHALMOLOGY

The American Board of Ophthalmology announces an important change in its method of examination of candidates for the Board's certificate.

Examinations will be divided into two parts. Candidates whose applications are accepted will be required to pass a WRITTEN examination which will be held simultaneously in various cities throughout the country approximately 60 days prior to the date of the oral examination.

The WRITTEN examination will include all of the subjects previously covered by the practical and oral examinations.

ORAL examinations will be held at the time and place of the meeting of the American Medical Association and of the American Academy of Ophthalmology and Otolaryngology, and occasionally in connection with other important medical meetings. The ORAL examination will be on the following subjects: External Diseases, Ophthalmoscopy, Pathology, Refraction, Ocular Motility, Practical Surgery.

Only those candidates who pass the written examination and who have presented satisfactory case reports will be permitted to appear for the oral examination.

Examinations scheduled for 1939: WRITTEN, March 15th and August 5th. ORAL, St. Louis, May 15th. Chicago, October 6th.

Applications for permission to take the written examination March 15th must be filled with the Secretary not later than February 15th.

Application forms and detailed information should be secured at once from

Dr. John Green, Secretary  
6830 Waterman Avenue  
St. Louis, Mo.



### EXAMINATIONS AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The general oral, clinical and pathological examinations for all candidates, Part II Examinations (Groups A and B), will be conducted by the entire Board, meeting in St. Louis, Missouri, on May 15 and 16, 1939, immediately prior to the annual meeting of the American Medical Association. Notice of time and place of these examinations will be forwarded to all candidates well in advance of the examination dates.

Candidates for reexamination in Part II must request such reexamination by writing the Secretary's Office before April 1, 1939. Candidates who are required to take reexaminations must do so before the expiration of three years from the date of their first examination.

Application for admission to Group A, May, 1939, examinations must be on file in the Secretary's Office by March 15, 1939

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, (6) Pennsylvania.

### WORLD CONGRESS OF WORKERS FOR CRIPPLES

The Fourth World Congress of Workers for Cripples will convene in London, England, on July 16, 1939, and continue through July 22. This Congress is under the auspices of the International Society for Crippled Children and the Central Council for the Care of Cripples.

Subjects to be considered include preventive orthopedics in childhood; vocational training and subsequent employment of the crippled child, and the industrial cripple. Reservations can be made through Frances Shirley, Chairman, Transportation Committee, 1426 Denniston Avenue, Pittsburgh, Pa.



### THIRD CONGRESS OF PAN-PACIFIC SURGICAL ASSOCIATION

Honolulu, Hawaii, will be the host to the Third Congress of the Pan-Pacific Surgical Association from September 15 to 28, 1939. The occasion will mark the tenth anniversary of the founding of this association. A Hospital Institute, devoted to the exchange of ideas on the management and organization of the modern hospital, will be an important subsidiary feature of the Congress. Honolulu has much to attract in its tropical beauty and picturesque topography. Those interested in attending the Congress should communicate with Dr. F. L. Reichert, San Francisco.



### SYMPOSIUM ON THE PUBLIC HEALTH SIGNIFICANCE OF THE VIRUS AND RICKETTSIAL DISEASE

Harvard School of Public Health offers a short course of lectures, clinics and demonstrations on the virus and rickettsial diseases, with special emphasis on their public health significance, to be held at the School during the week of June 12-17, 1939. Lectures on the etiology, epidemiology and methods of control of these diseases will occupy five mornings with special clinics and demonstrations in the afternoons. On the last morning a panel discussion will be held on the three main topics presented in the symposium. The fee for the course will be \$25.00, payable at any time up to June 12. Enrolment, however, should be arranged before June 1 because of limited facilities. For further information write the Secretary of the School of Public Health, 55 Shattuck Street, Boston, Mass.



### AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

The American Congress on Obstetrics and Gynecology will hold its first session in Cleveland, September 11-15, 1939. The Congress is sponsored by the American Committee on Maternal Welfare, Inc., for the purpose of studying our present day problems on obstetrics and gynecology and their solution. The membership fee is \$5.00, which includes a year's membership in the American Committee on Maternal Welfare as well as registration in the Congress. Further information may be obtained from the Central office, 650 Rush Street, Chicago.

(Continued on Next Page)



An outline of the Preliminary Program of the Congress follows:—

#### MEDICAL SECTION

(Other sectional programs for mornings and round tables will be published as they are available).

Monday, September 11, 1939

The Thyroid and Pregnancy  
Heart Disease and Pregnancy  
Diabetes and Pregnancy  
Tuberculosis and Pregnancy  
Nutritional Factors and Pregnancy  
The Surgical Abdomen complicated by Pregnancy  
The Treatment of Abortions

Tuesday, September 12, 1939

The New Conception of Ovarian Neoplasms  
Carcinoma of the Uterus  
Endometriosis  
Ectopic Pregnancy  
Sterility in the Female

Wednesday, September 13, 1939

Reduction of the Operative Incidence in Obstetrics  
Labor Complicated by the Contracted Pelvis  
Dystocia Due to Soft Parts  
Pathology and Treatment of the Third Stage of Labor

Thursday, September 14, 1939

Present Day Fundamental Knowledge of Hormones and Endocrine Glands.

Problems of Adolescence

Problems of Menopause

Diseases of the Mammary Gland

Friday, September 15, 1939

Sulfanilamide in Obstetrics and Gynecology

Pyelitis

Chronic Pelvic Infections

Immediate and Remote Complications Following Labor

#### ROUND TABLES

Running concurrently each day 11:45 to 1:15

The Toxemias of Pregnancy

Genital Infections

Obstetric and Gynecologic Hemorrhages

The Fetus and the Newborn

Forceps, Occiput-Posterior, and Breech Presentation

Anesthesia, Analgesia and Amnesia in Labor

#### JOINT AFTERNOON SESSIONS

Monday, September 11, 1939

Neonatal Care

Tuesday, September 12, 1939

Plans for Prevention and Control of Uterine Cancer

Wednesday, September 13, 1939

Extension Education on Maternal and Neonatal Care

Thursday, September 14, 1939

Economic Aspects of Maternal Care

Friday, September 15, 1939

Correlation of and Attempt to Digest All Proceedings

#### JOINT EVENING SESSIONS

Monday, September 11, 1939

Legal Aspects of Maternity

Tuesday, September 12, 1939

Humanitarian Aspects

Wednesday, September 13, 1939

Sociologic Aspects

Thursday, September 14, 1939

Ethical Aspects

## • OBITUARIES •

### FRANCIS WINTHROP PYLE, M.D.

1874 - 1938

For thirty-five years Dr. Francis Winthrop Pyle was a leader in the medical life of Bridgeport, his judgment was relied upon, his council sought and his place can be filled by no one man. We shall miss him.

Dr. Pyle was born in Bridgeport in 1874, the son of Edwin I. Pyle and Mary Wells Knight Pyle. His early education was received in the Bridgeport Schools, graduating from High School with high honors. He received his Bachelor of Arts Degree from Yale University in 1897. From there he went to the College of Physicians and Surgeons at Columbia where he received his medical degree. After a two year internship at Bellevue, he came to Bridgeport and started practice in 1904 where he became associated with Dr. J. W. Wright of the Galen Hospital. After eight years he established his own office and practice. In a short time Dr. Pyle became a fine representative of the highest type of practitioner of medicine. He combined his function of physician with that of personal friend and family counselor. With all his duties he still found time to keep abreast of the advances in medicine.

During the war his duties were doubly increased with the addition of being medical examiner of the draftees. For twenty years Dr. Pyle was one of the Chiefs of the medical service at the Bridgeport Hospital. In 1924 his medical confreres elected him President of the Bridgeport Medical Association.

Dr. Pyle is survived by his wife, Adele Gros Claude Pyle, a daughter Mrs. Horton Spitzer, two grand-children and a brother Edwin Pyle of Boston.

J. Stanley Nickerson, M.D.

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### JOHN FRANKLIN AXTELLE, M.D.

1854 - 1938

John Franklin Axtelle was born on August 28th, 1854 at Morristown, New Jersey, the son of Stephen D. and Nancy Sutton Axtelle. He

was a descendant of Thomas Axtelle who settled in Sudbury, Massachusetts in 1622.

While a small boy the family moved to Minneapolis, Minnesota, where he was educated in the public schools of that city. He obtained his Medical Degree from Long Island Medical College in 1878. The following year he began the practice of medicine in Hartford and was actively engaged up to the time his health failed and he retired.

On June 6th, 1934 he entered the Masonic Home at Wallingford where he remained until his death on February 8th, 1938.

He was one of the first local practitioners to give special attention to obstetrics.

Dr. Axtelle became a member of the Hartford County Medical Association in 1880 and in the same year he became a member of The Hartford Medical Society. He was also a member of the Connecticut State Medical Society and the American Medical Association.

He was interested in fraternal activities being a Mason, a Shriner, an Odd Fellow, as well as a member of the Knights of Pythias. In religious matters he was a Congregationalist and in politics, a Republican. His chief recreation was yachting and he was a member of the Hartford Yacht Club.

Dr. Axtelle was twice married. In 1882 he married Mrs. Ella M. Norwall, nee Cook, who died in 1895. In 1903 he married Miss Stella D. Waterman who passed away about twelve years ago.

Frank T. Oberg, M.D.

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**WILLIAM MARTIN HILL, M.D.**

1868 - 1938

Dr. William Martin Hill was born in Potsdam, N. Y., October 21, 1868, the son of Charles Hill and Martha Irene Miller. He was educated in the schools of Potsdam and graduated from the State Normal School there. During early manhood he was principal of a school in Hampton Bays, Long Island. While there he met and married in 1893 Anna Elizabeth Squires who survives him. He entered the University of Virginia and graduated from the School of Medicine in 1897. Following his graduation he settled in Noank and served the community faithfully as physician from then until the time of his death.

Dr. Hill was a devout member of the Noank

Methodist Church, a member of Charity & Relief Lodge of Masons in Mystic and President of the Board of Trustees of the Mystic and Noank Library and of the Noank Valley Cemetery. He served the Town of Groton as member of the School Board for a number of years and was School physician for the local Grammer School and the Robert E. Fitch High School. Dr. Hill was a member of the staff of the old Memorial Hospital and later of the Home Memorial Hospital in New London. He was a past president of the New London County Medical Association, a member of the Connecticut State Medical Society and of the American Medical Association.

Dr. Hill had not been in good health for some time but had attended to his duties and made calls on the morning of his death. He died late in the afternoon of June 8, 1938, very suddenly, while resting quietly at his home. He is survived by his wife, Anna Squires Hill; three sons, Dr. E. Roland Hill of Noank, Norbert Hill of Gales Ferry and New York and Kenneth Hill of Washington, D. C.; and two daughters, Mrs. Constance Hathaway of Maplewood, N. J., and Mrs. Frances Jones of Louisville, Ky.

The many and varied activities of Dr. William Hill and his professional skill and kindness left an indelible impression on the community in which he lived, for he was deeply loved and will be greatly missed by all who knew him.

E. L. Douglas, M.D.

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**GEORGE N. BELL, M.D.**

1870 - 1938

George Newton Bell, M.D., was born May 30th, 1870, in Blandford, Mass., the son of Dr. Newton Bell and Mary (Hatch) Bell. Very early in his life his family moved to Windsor, Conn., where his father practiced medicine for many years.

Dr. Bell attended the Windsor graded school and then graduated from the Hartford Public High School. In 1892 he graduated from the Yale School of Medicine, with an M.D. Degree, following which he interned for one year at the Hartford Hospital. In 1893 he was licensed and in the same year began the practice of medicine in Hartford, Conn., in which city he practiced throughout his entire life.

In 1900 he married Elizabeth C. Palmer of Middle Haddam, Conn. There were no children.



During the first few years of his practice he was engaged in general medicine, but about the turn of the century he confined himself more and more to general surgery, so that for the last 25 years of his activities he confined himself entirely to general surgery.

For many years he was associated with the late Dr. O. C. Smith.

He was associated with the Hartford Hospital for many years, first as Assistant Surgeon, then as Visiting Surgeon, and after giving up active practice because of ill health in 1928, he became a Director.

Outside of his work and family, his main interests were books and travel.

He was a member of the Hartford County Medical Association, Hartford City Medical Society, Connecticut State Medical Society, life member of the American College of Surgeons, and also a member of the New England Surgical Society.

For 35 years he led an active professional life and his advice and help were sought, not only by many patients, but also by members of his own profession and the Directors of the Hartford Hospital.

On September 10th, 1938, a cerebral hemorrhage removed from our midst George N. Bell, M.D., in whose judgment and skill we had the greatest confidence.

H. Gildersleeve Jarvis, M.D.

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**RAYNAULD DOBSON RICHMAN, M.D.**  
1885 - 1938

News of the passing of Dr. Raynauld Dobson Richman came as a severe shock and brought sadness to the hearts of his many friends both in medical and military circles.

Active in his duties as Surgical Advisor of the Aetna Life Insurance Company, there were many not aware of his final illness until they learned that he had "slipped away" the morning of September 16, 1938. For eighteen years he served as an expert directing the medical destinies of thousands of grateful patients injured in the course of their employment. During the past two years, in spite of major injury to his eyesight, the doctor successfully maintained his

position and, through indomitable courage, carried on to the end.

Dr. Richman served abroad during the World War. He enlisted as a private in the Second Ambulance Corps of the New York National Guard May 2, 1912, and soon received his commission as lieutenant in the Medical Corps. June 2, 1915 he was commissioned captain. The doctor served on the Mexican border in 1916. On July 25, 1918 he was commissioned a first lieutenant in the Medical Corps of the Officers Reserve. August 28, 1918 he was transferred to the 248th Ambulance Corps of the 12th Division and on November 17, 1918 moved to the Sanitary School at Langres. A month later he was assigned to Base Section 5 and on May 2, 1919 commissioned a captain in the Medical Division of the ORC, honorably discharged October 30, 1919.

His interest in military affairs then continued through the Connecticut National Guard, where he played a major part through the years. On February 4, 1935, as lieutenant colonel, he was retired because of an eye injury, but to the day of his death his devotion to the Service never flagged.

He was born in Morton, N. Y., son of Dr. Alonzo Richman and grandson of Dr. John Richman. Graduated from the University of Buffalo School of Medicine in 1908, service in his chosen field continued for thirty years. As doctor, soldier, and Surgical Advisor few men leave such a host of friends.

Donald B. Cragin, M.D.

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## DIABETES MORTALITY

Only among old people have diabetes death rates increased in the past five years. At the younger ages the death rates have continued to show great improvement.

Diabetes mortality continues to show marked concentration in middle-aged and older women. This characteristic is becoming accentuated.

In the teens, many more girls die of diabetes than boys.—*Baker Clinic, Boston.*

## • Quarto Notes •

### CLINICAL LABORATORY METHODS AND DIAGNOSIS

by R. B. H. Gradwohl, M.D.

Director of the Gradwohl Laboratories and Gradwohl  
School of Laboratory Technique, St. Louis, Mo.

2nd edition	1607 pages	\$12.50
492 illustrations	44 color plates	
St. Louis	C. V. Mosby Company	1938

This text ably covers an enormous field. It could easily be broken down into a number of complete textbooks, each on a special subject. There are, for instance, nearly 300 pages on HEMATOLOGY — 100 more pages and 24 full page color plates added since the first edition three years ago. Recent advances in hematology are included, such as descriptions of the various methods of performing the erythrocyte sedimentation test; a lengthy discussion of the Schilling count; bone marrow culture methods; and even detailed plans for establishing a "blood bank".

PARASITOLOGY and TROPICAL MEDICINE occupy nearly 300 pages, with much of the text and more than 100 drawings and photographs contributed by Professor Pedro Kouri, director of the Department of Parasitology of the Medical School of the University of Havana, Cuba. There are nearly 200 pages on CLINICAL BACTERIOLOGY with over 50 more on SEROLOGY. These sections too are right up to date, for they contain such recent methods as the Neufeld pneumococcus typing technique and opsonocytophagocytic tests. URINE and BLOOD CHEMISTRY cover over 200 pages.

Besides these book-sized divisions, there are many other useful chapters including Postmortum Examinations, Tissue Cutting and Staining, Preparation of Museum Specimens, Toxicological Technique, and an interesting new chapter on Detection of Crime by Laboratory Methods — on which subject Dr. Gradwohl is an authority because of his experience as Director of the Research Laboratory of the St. Louis Police Department.

Under "Special Tests" are described such up-to-the-minute subjects as: Laboratory tests for pregnancy with prolan bio-assay methods used in studying embryonal tumors; liver function tests; the preparation of allergy products; the leukopenic index; blood and urine sulfanilamide determinations; and blood ascorbic acid titration methods.

In addition to being a compilation of modern laboratory procedures, this text includes much discussion of the interpretation and clinical significance of these tests. Some of the newer concepts of disease processes are also presented. There are, moreover, abundant bibliographical footnotes, so that additional references are readily available.

For the clinician, laboratory worker and medical student

this book should prove to be invaluable as a text as well as a veritable reference library of laboratory procedures.

W. F. Smith



### TEXT BOOK OF PATHOLOGY

by E. T. Beti, M.D.

Professor of Pathology in the University  
of Minnesota, Minneapolis, Minn.

Pp. 871, with 412 illustrations and 2 color plates.	\$9.50
Philadelphia	Lea and Febiger 1938

This third edition follows the trend in texts on pathology by giving more space to pathological physiology and some reference to clinical manifestations of the disease process. The bibliography has been lengthened and there are 123 pages of new or corrected material.

An impressive list of contributors include Hal Downey, B. J. Clawson, J. S. McCartney and C. J. Watson. Dr. Downey has contributed an excellent section on diseases of the blood. The sections on the kidney and tumors are quite clear considering the unsettled condition of the pathology of those subjects.

Emphasis has been placed on systemic pathology which should make this book useful to the advanced student as well as the practitioner. The illustrations and photomicrographs are carefully and excellently reproduced.

L. P. Hastings



### DOCTOR BRADLEY REMEMBERS

by Francis Brett Young

Author of "They Seek a Country"

522 pages	\$2.75
New York	Reynal & Hitchcock 1938

Although the subject, the country doctor, has been popularized recently with almost disastrous results, there is a new appeal in this story filled with the hedgerows and mining collieries of rural England. The author reveals an unusual insight into human nature, his characters are interesting and his philosophy of life is wholesome. In spite of the fact that the outcome of many impending crises is evident to the reader long before they occur, interest is well maintained to the end of the story.

Perhaps that for which this novel should receive its real plaudits is the manner in which medical events of historic interest are woven into the tale. The art of the self-trained bonesetter; Lister and the carbolic age of antiseptics followed by asepsis and the modern operating room; the discovery of specific organisms responsible for specific diseases; the advent of the automobile, electric lights and telephone; the development of the subsidized hospital, an adjunct to a modern industrial plant; the rise of the specialist; the development of surgery of the chest and of the brain; and, finally, the coming of the Invalidity Insurance Act to England, health insurance with its panel of patients voluntarily apportioned to each doctor,— these all have their place in the development of this novel.

The book can be recommended as one of interest to either lay or professional readers, although the more critical will find it wanting in typographical perfection.



## Charter and By-laws

### Connecticut State Medical Society

#### AN ACT REVISING THE CHARTER OF THE CONNECTICUT MEDICAL SOCIETY AND CHANGING ITS NAME TO THE CON- NECTICUT STATE MEDICAL SOCIETY

##### General Assembly

January Session, A.D., 1931

*Be it enacted by the Senate and House of Representatives in General Assembly convened:*

Section 1. The charter of The Connecticut Medical Society, approved June 5, 1834, is amended to read as follows: All persons who are, at the time of the passage of this act, members of The Connecticut Medical Society and all physicians and surgeons who shall hereafter be associated with them in pursuance of the provisions of this act shall be and remain a body politic and corporate by the name of The Connecticut State Medical Society; and by that name they and their successors shall and may have perpetual succession; shall be capable of suing and being sued, pleading and being impleaded, in all suit of whatever name and nature; may have a common seal and may alter the same at pleasure and may also purchase, receive, hold and convey any estate, real and personal, to an amount not exceeding one hundred thousand dollars.

Section 2. The superintendence and management of the corporation shall be vested in a board to be known as "The House of Delegates of The Connecticut State Medical Society," which board shall have power to establish officers in said corporation and prescribe the duties of the several officers and of the members of said corporation and may fix their compensation; to establish the conditions of admission to and dismissal and expulsion from said society; to lay a tax, from time to time, upon the members and to collect the same; to hold and dispose of all moneys and other property belonging to the corporation in such manner as it may deem advisable to promote the objects and interests of the society and in general to make such by-laws and regulations for the due government of the society, not repugnant to the statutes of the United States or of this state, as may be deemed necessary.

Section 3. The House of Delegates of The Connecticut State Medical Society shall be composed of, (1) the President, the President-Elect, Treasurer and Secretary of the Society; (2) delegates to be elected annually as hereinafter provided, by the several county medical associations in this State which heretofore have been and are affiliated with The Connecticut State Medical Society and (3) eight councilors to be elected from time to time as hereinafter provided.

Section 4. An annual meeting of the corporation, for the election of officers and such other business as may, from time to time, arise, shall be held during the month of May in each year and upon such day in said month as The House of Delegates shall, from time to time, prescribe.

Section 5. At a meeting to be held at least twenty days in advance of the annual meeting of the corporation

in each year, every affiliated county association shall elect a delegate or delegates to represent it in "The House of Delegates" of this society in the proportion of one delegate to each thirty-five members, or any part of that number, and the secretary of such affiliated county association shall send a list of such delegates to the secretary of this corporation at least twenty days before the date of such annual meeting.

Section 6. There shall be in "The House of Delegates," one councilor from each affiliated county medical association. The councilors holding office at the time of the passage of this act shall serve out the terms of office for which they were elected. At their annual meeting to be held in 1931, the affiliated county medical associations for the counties of Hartford, New London, Windham and Middlesex shall each elect one councilor who shall serve for two years, and at their annual meeting in 1932 the affiliated county medical associations for New Haven, Fairfield, Litchfield and Tolland counties shall each elect one councilor, who shall serve for two years. Thereafter each county, in groups as above mentioned, shall, biennially, elect a councilor to fill said office for a term of two years. Any vacancy in said office may be filled by the county association of the county in which the vacancy occurs, by election to fill the unexpired portion of the term.

Section 7. The secretary of each affiliated county medical association in this state shall, within ten days following any meeting of such association at which new members are elected, file with the secretary of the society a list of all members of such association who are at the time in good and regular standing, and thereupon all such persons shall become members of The Connecticut State Medical Society without further action.

Approved May 25, 1931. (Special Act 427, 1931.)

#### BY-LAWS

##### Chapter I

Section 1. Name. The name and title of this organization shall be The Connecticut State Medical Society.

Section 2. Purposes of the Society. The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Connecticut, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the material interests of its members and to protect them against imposition; to enlighten and direct public opinion in regard to the great problem of State medicine, so that the profession shall become more capable and honorable within itself and, more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

Section 3. Component Associations. Component

Associations shall consist of those county medical associations which heretofore have been and now are affiliated with The Connecticut State Medical Society.

Section 4. Composition of Society. This Society shall consist of members, delegates, guests, and honorary members.

Section 5. Members. Members of this Society shall be members of the component county medical associations.

Section 6. Delegates. (1) Delegates shall be those members who are elected by the component county associations; (2) the Councilors of their respective component associations in the House of Delegates of this Society.

Section 7. Guests. Any distinguished physician not a resident of this State who is a member of his own State Association, may become a guest during any annual session on invitation of the officers of this Society and shall be accorded the privilege of participating in all the scientific work for that session.

Section 8. Honorary Members. Eminent physicians, may be elected Honorary Members by a major vote of the House of Delegates after nomination of one year, but shall not exceed three in any one year.

Honorary Members shall have all the privileges accorded by Section 7 to guests.

## Chapter II. Membership

Section 1. The name of a physician upon the properly certified roster of members of a component association, who has paid his annual assessment, shall be prima facie evidence of membership in this Society

New members elected to the Society by a component association at any time during the course of the fiscal year shall be assessed and shall pay the full dues for that year.

The annual tax shall be collected from all such members except the secretaries of County Medical Associations, but the taxes of any member may be remitted by vote of the House of Delegates upon recommendation of any County Medical Association.

Section 2. Any person who is under sentence of suspension or expulsion from a component association, or whose name has been dropped from its roll of members, shall not be entitled to any of the rights or benefits of the Society, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Section 3. Each member in attendance at the annual session shall enter his name on the registration book, indicating the component association of which he is a member.

## Chapter III. House of Delegates

Section 1. The House of Delegates shall be the legislative and business body of the Society, and shall consist of (1) the President, Treasurer and Secretary of the Society; (2) Delegates elected by the component county medical associations; and (3) the Councilors.

Section 2. The House of Delegates shall meet on the first day of the annual session. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General Meetings. The order of business shall be arranged as a separate section of the programme.

Section 3. Each component association shall be entitled to send to the House of Delegates each year, one delegate for every thirty-five members, or any part of that number.

Section 4. Fifteen delegates shall constitute a quorum.

Section 5. It shall, through its officers, Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Society, and shall constantly strive to make each annual session a stepping-stone to further advancement.

Section 6. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.

Section 7. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interests in such county associations as already exist and for organizing the profession in counties where associations do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality, and shall continue these efforts until every physician in every county in the State who can be made reputable has been brought under medical society influence.

Section 8. It shall encourage post-graduate and research work, as well as home study, and shall endeavor to have the results discussed and utilized.

Section 9. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-laws of that body.

Section 10. It shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates.

Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

Section 11. It shall approve all memorials and resolutions issued in the name of the Society before the same shall become effective.

Section 12. Sections and District Societies. The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections and for the organization of such Councilor District Associations as will promote the best interests of the profession, such associations to be composed exclusively of members of component county associations.

## Chapter IV. Sessions and Meetings

Section 1. The Society shall hold an annual session, during which there shall be held daily General Meetings which shall be open to all registered members, guests and honorary members.

Section 2. The time and place for holding each annual session shall be fixed by the House of Delegates.

Section 3. Special meetings of either the Society or the House of Delegates may be called by the President or the Council and shall be called by the President on petition of 10 members of the House of Delegates or 50 members of the Society.

Section 4. General Meetings. All registered members may attend and participate in the proceedings and discussions of the General Meetings and of the Sections.



The General Meetings shall be presided over by the President or by one of the Vice-Presidents, and before them shall be delivered the address of the President and the orations.

Section 5. The General Meeting may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and the public.

#### Chapter V. Officers

Section 1. The Officers of this Society shall be a President, a President-Elect, two Vice Presidents, a Secretary, a Treasurer, and eight Councilors.

Section 2. The officers, except the Councilors, shall be elected annually. At their annual meeting to be held in 1931, the affiliated county medical associations for the counties of Hartford, New London, Windham and Middlesex shall each elect one Councilor who shall serve for two years, and at their annual meeting in 1932 the affiliated county medical associations for New Haven, Fairfield, Litchfield and Tolland counties shall each elect one Councilor, who shall serve for two years. Thereafter each county, in groups as above mentioned, shall, biennially, elect a Councilor to fill said office for a term of two years. Any vacancy in said office may be filled by the county association of the county in which the vacancy occurs, by election to fill the unexpired portion of the term.

Section 3. All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

Section 4. The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the last day of the General Session, and no person shall be elected to any such office who has not been a member of the Society for the past two years.

#### Chapter VI. Duties of Officers

Section 1. The President shall preside at all meetings of the Society and of the House of Delegates; shall appoint all committees not otherwise provided for; shall deliver an annual address at such times as may be arranged, and perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office and, as far as practicable, shall visit by appointment the various sections of the State and assist the Councilors in building up the county associations and in making their work more practical and useful.

Section 2. At the Annual Meeting in 1937, and at each Annual Meeting thereafter, the Council shall nominate to the House of Delegates, a President-Elect who shall become the President of the Society at the conclusion of the Annual Meeting of the next following year without further formality. The duties of the President-Elect shall be to aid and assist the President in any way designated by him, to familiarize himself with the activities of the Society, and to attend the meetings of the Council and take part in its deliberations but without vote.

Section 3. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of the President's death, resignation, or removal, the Council shall select one of the Vice-Presidents to succeed him.

Section 4. The Treasurer shall give bond in the sum of \$5,000, the manner of bonding to be left to the Council. He shall demand and receive all funds due the Society, together with the bequests and donations. He shall pay

money out of the treasury only on a written order of the President, countersigned by the Secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

Section 5. The Secretary shall attend the General Meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be ex-officio Secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates of the annual sessions. He shall, with the cooperation of the secretaries of the component associations, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county association, and, on request, shall transmit a copy of this list to the American Medical Association. He shall aid the Councilors in the organization and improvement of the county associations and in the extension of the power and usefulness of this Society. He shall conduct the official correspondence, notify members of meetings, officers of their election, and committees of their appointment and duties. He shall employ such assistants as may be ordered by the House of Delegates. He shall supply each component association with the necessary blanks for making their annual reports. Acting with the Committee on Scientific Work, he shall prepare and issue all programmes. The amount of his salary shall be fixed by the Council.

#### Chapter VII. Council

Section 1. The Council shall consist of one Councilor from each county and the President, the President-Elect, the Secretary, the Treasurer, the Editor of the Journal, and the Legislative Secretary. It shall be the Finance Committee of the House of Delegates. Five Councilors shall constitute a quorum.

The Board of Councilors shall appoint from its own members two members who, with the Treasurer of the Society, shall constitute a sub-committee to be designated a Committee on the Permanent Funds, whose duty it shall be to advise on the investment of such funds as the Society may have or receive by bequest or donation, according to the laws of the State of Connecticut governing trust funds. This committee shall, through the Chairman of the Council, recommend to the House of Delegates the disposition to be made of the permanent funds, both principal and income.

Section 2. The Council shall meet daily during the session, and at such other times as necessity may require, subject to the call of the chairman or on petition of three Councilors. It shall meet on the last day of the annual session of the Society to organize and outline work for the ensuing year. It shall elect a chairman and a clerk, who, in the absence of the Secretary of the Society, shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the House of Delegates.

Section 3. The Board of Councilors shall constitute the nominating committee of the Society. They shall report as such to the House of Delegates on the first day of

the general session. After the report has been submitted an opportunity shall be given for other nominations to be made.

Section 4. Each Councilor shall be organizer, peace-maker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component associations where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county associations and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the House of Delegates.

Section 5. The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component associations, or to this Society. All questions of an ethical nature brought before the House of Delegates or the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component associations on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Section 6. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary. All money received by the Council and its agents, resulting from the discharge of the duties assigned to them, must be paid to the Treasurer of the Society. As the Finance Committee, it shall annually audit the accounts of the Treasurer and Secretary and other agents of this Society, and present a statement of the same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of this Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary. In the event of a vacancy in the office of the Secretary or the Treasurer, the Council shall fill the vacancy until the next annual election.

Section 7. The Council shall serve as a Board of Review for cases of claimed malpractice as may be referred to it by any component County Association's Committee on Medical Ethics and Department.

### Chapter VIII. Committees

Section 1. The standing committees shall be as follows:

A Program Committee.

A Committee on Public Policy and Legislation.

A Committee on Medical Examination and Medical Education.

A Committee on Honorary Members and Degrees.

A Committee on Arrangements, and such other committees as may be necessary. Such committees shall be elected by the House of Delegates unless otherwise provided.

A Committee on Public Relations.

Section 2. The Program Committee shall consist of three members which shall be nominated by the Council and elected by the House of Delegates. At the annual

meeting of the House of Delegates in 1938 the Council shall nominate one member of the Society to serve as a member of the Program Committee for three years, one member to serve as a member of the Committee for two years, and one member to serve as a member of the Committee for one year. Annually thereafter the Council shall nominate to the House of Delegates one member of the Society to serve as a member of the Program Committee for three years. The Council shall designate the chairman of the Committee. The duties of the Program Committee shall be to arrange the scientific program for the meetings of the Society and it shall prepare such program for the Annual Meeting and submit it to the Executive Secretary of the Society for publication not less than two months preceding the date of the meeting.

Section 3. The Committee on Public Policy and Legislation shall consist of one member from each component association, and the President and Secretary and the Committee on National Legislation. Under the direction of the House of Delegates it shall represent the Society in securing and enforcing legislation in the interest of the public health and scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local, state, and national affairs and elections.

Section 4. The Committee on Medical Examination and Medical Education shall consist of five members, who shall be appointed in accordance with Section 4717 of the general statutes of the State of Connecticut. The committee shall conduct the medical examination of candidates for certificates of qualifications for license to practice medicine in the State in accord with the requirements of the Medical Practice Act. It shall annually present a written report to the House of Delegates. The committee shall also be a committee on medical education and shall cooperate with the council of education of the American Medical Association in the effort to elevate the standard of medical education in the United States.

Section 5. The Committee on Honorary Members and Degrees may present annually to the House of Delegates the names of not more than three eminent physicians, as candidates for honorary membership in this Society. Such candidates may be elected honorary members in accordance with the provisions of Chap. I, Section 8, of the By-laws.

Section 6. The Committee on Arrangements shall be appointed by the component association in which the annual session is to be held. It shall provide suitable accommodations for the meeting places of the Society and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the Secretary for publication in the programme, and shall make additional announcements during the session as occasion may require.

Section 7. At the Annual Meeting in 1938 and annually thereafter, the Council shall nominate to the House of Delegates one member of each component county association to serve for the period of one year on the Society's Committee on Public Relations. The chairman of this Committee shall be designated annually by the Council.



The duties of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine. If the Committee so desires, its deliberations and conclusions may be reviewed and passed upon by the Council of the Society, but such approval shall not be mandatory.

#### Chapter IX. Funds and Expenses

Funds shall be raised by an equal per capita assessment on each component association. The amount of the annual assessment per member shall be fixed by the House of Delegates.

Funds may also be raised by voluntary contributions, for the Society's publications, and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Society, for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be referred to the Finance Committee before action is taken thereon.

#### Chapter X. Referendum

Section 1. A General Meeting of the Society may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Society, who may vote by mail or in person, and, if the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding on the House of Delegates.

Section 2. The House of Delegates may, by a two-thirds vote of its members present, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

#### Chapter XI. County Associations

Section 1. All County Associations now in affiliation with the Connecticut State Medical Society shall be component parts of this Society.

Section 2. Each County Association shall judge of the qualification of its members, but as such associations are the only portals to this Society and to the American Medical Association, all reputable and legally registered physicians, except those who practice or claim to practice or lend support to any exclusive or irregular system of medicine, shall be entitled to membership.

No physician shall be admitted to or retain membership in a County Medical Association after the expiration of his present contract who has agreed to furnish medical services to any organization or union for a stipulated sum per member, or for other consideration than the regular local fee for such services.

Section 3. Any County Medical Association may suspend or expel any member who is guilty of improper or unprofessional conduct, by a two-thirds vote of the members present and voting at any regular meeting, provided due notice has been given on the programme of said meeting at least ten days before its session. When from any cause a member of the Connecticut State Medical Society ceases to be a member of one of the component county medical associations, his membership in the Connecticut State Medical Society shall terminate, but any physician who may feel aggrieved by the action of the association of

his county in refusing him membership or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Section 4. In hearing appeals the Council may admit oral or written evidence as in its judgment will be best and to most fairly present the facts, but in case of every appeal, both as a Board and as individual councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Section 5. When a member of a component association in this state or any component association of the American Medical Association removes to another county in this state or takes up his residence within this state and presents a certificate signed by the president or secretary of the component association stating that he is a member in good standing and evidence that he is legally qualified to practice medicine in the State of Connecticut, he may, upon recommendation of the Committee on Credentials, be elected to membership in a component association of this Society by a two-thirds vote of the members voting.

When a physician applies for membership, or when an application is made to be received on transfer from another state, the secretary of the component association shall forward the applicant's name and address to the biographic department of the American Medical Association for such information as may be on file relative to his record. Printed forms for this purpose will be furnished by the Secretary of this Society. After the adoption of this By-law, no new member shall be enrolled or accepted on transfer from another state until this provision shall have been carried into effect.

Section 6. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the association in whose jurisdiction he resides.

Section 7. Each component association shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral, and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the Society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 8. At some meeting in advance of the annual session of this Society, each county association shall elect a delegate or delegates to represent it in the House of Delegates of this Society in the proportion of one delegate to each thirty-five members, or any part of that number, and the Secretary of the Association shall send a list of such delegates to the Secretary of this Society at least twenty days before the annual session.

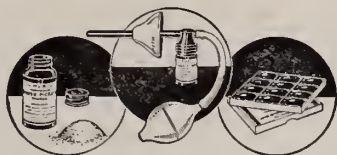
In the case of death, illness or disability of a delegate, the President of the County Association in which the vacancy occurs shall appoint a substitute delegate, with full power to represent his county during the delegate's disability, or until the successor of such appointee is elected at the next meeting of the County Medical Association. Any vacancy in the office of Councilor may be filled by the County Association of the county in which the vacancy occurs, by election to fill the unexpired portion of the term.

Section 9. The Secretary of each component associ-

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ation shall keep a roster of its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of registration in this State, and such other information as may be deemed necessary. In keeping such roster the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 10. The dues of the Society shall be due and payable on January 1 of each year and the fiscal year of the Society shall terminate on December 31 of each year.

The Secretaries of the component county associations shall be charged with the collection from the members of their associations, the dues assessed by this Society. Bills for such dues shall be rendered to all members immediately following the first of January of each year, and the Secretaries of the component county associations shall forward to the Treasurer of this Society on or before the 10th of each month, all monies collected by them and due the Treasurer of the Society.

Section 11. The several county medical associations shall have power to adjourn; to call special meetings, as they shall deem expedient; and to adopt such by-laws as they find desirable, not contrary to the laws of this State

or the charter and by-laws of The Connecticut State Medical Society.

### Chapter XII. Miscellaneous

Section 1. No address or paper before this Society, except those of the President and orators, shall occupy more than twenty minutes in its delivery; and no member shall speak longer than five minutes, nor more than once on any subject except by unanimous consent.

Section 2. All papers read before the Society or any of the Sections shall become its property. Each paper shall be deposited with the Secretary before reading. No paper shall be read before this Society which has been previously published or read before any other organization.

Section 3. The deliberations of this Society shall be governed by parliamentary usage as contained in Roberts' Rules of Order, when not in conflict with the charter and by-laws.

Section 4. The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

### Chapter XIII. Amendments

These By-laws may be amended at any annual session by a majority vote of all delegates present at that session, after the amendment has been laid on the table until the next annual session. If however, the proposed alteration has been published in the notice of the session, it may be acted upon after it has laid on the table one day.

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40 per cent self-supporting citizens. The 22 million inhabitants of the United States now on the public relief rolls produce one-quarter of a million babies every year. For every 100 children born to self-supporting parents, relief parents produce 160 children—*Rocky Mt. Med. Jour.*, Dec. 1938.

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**A.**—Your Family Physician will recommend an Eye Physician (medical doctor).

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**A.**—Because the Eye Physician with his medical training knows the eye in its relation to the body. He can determine whether headaches,

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## WHAT SHOULD BE THE POSITION OF MEDICAL PROFESSION

(Concluded from Page 65)

blessing. It is worth almost any price but not quite any price. To achieve it at the expense of freedom — even freedom to be stupid or stubborn, would be to pay too great price even for this invaluable asset.

Accordingly, the profession must be content to carry on and improve its present policies. These follow a simple but sensible plan. On the one hand, our members engaged in research tirelessly investigate the numberless problems proposed to them by modern medicine. When progress in any direction has been achieved, it is reported to another group whose task it is to subject the discovery to clinical tests. The results are promptly published and as fresh additions to our experience accumulate, we come to a sound appraisal of the value of the new therapy or the importance of the new idea.

We are often told that the most important single item in providing adequate medical care is a well trained profession. While our standards are self-imposed, you are entitled to know what we are doing in the way of undergraduate and postgraduate instruction and study.

Your familiarity with these activities will, I am sure, convince you that, under any system of medical care, your physician may be trusted to maintain and improve his own skill as well as the worth and dignity of his profession in the modern state.

—☆☆—

## SCIATIC NEURALGIA

(Concluded from Page 67)

hypertrophied portion of the ligament. The microscopic appearance of the pathological specimen is that of a mass of fibrous tissue with very little of the normal elastic tissue remaining. The fact that enlargement of the ligamentum flavum is sometimes found in connection with a ruptured disc is suggestive of a traumatic origin. Both of these lesions are fairly uncommon, although extremely popular at the moment.

### Conclusions

1. Sciatic neuralgia is a symptom rather than a disease.

2. Cases of prolonged and recurrent sciatic neuralgia, in which conservative therapy has

failed, should be investigated from the standpoint of intraspinal pathology.

3. Ruptured intervertebral disc lesions and enlargement of the ligamentum flavum are occasionally found.

4. The intrathecal use of alcohol is fraught with grave danger and should only be used in an individual in the last stages of a malignant tumor. In patients with intractable pain, cordotomy affords lasting relief and is preferable to alcohol injection, if the patient is in satisfactory condition for operation.

5. Alcohol injection of the sciatic nerve itself is also attended with risk.

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—☆☆—

## HORRIBLE EXAMPLE

In view of the crusading interest shown by many persons outside of Washington, D. C., and the government in the welfare of the employes of the Home Owners Loan Corporation, it is particularly interesting to note that Group Health Insurance under the government subsidized plan has encountered nearly all of the difficulties inherent in contract practice during its two years of existence. These difficulties have nothing to do with differences between the association and the District of Columbia Medical Society.

The association started out bravely in 1937 offering full medical and hospital coverage for its members, wives and dependents, whether one or ten, for the sum of \$3.30 a month. By the time the first birthday had rolled around, however, all applicants were required to take a physical examination at a cost of \$5.00. If accepted each applicant was obliged to pay a \$10.00 initiation fee for himself and \$1.00 for each dependent in addition to the regular monthly payment. The monthly payment was also increased to \$4.00 a month for a man and his wife and \$1.00 extra for each minor child. There is a prospect, now, that the number of visits by the doctor may have to be minimized by a charge of \$1.00 additional cash for each visit.

At the end of 1937, therefore, the Washington Group Health Association, while serving as the pretext for widespread criticism of the medical profession is rapidly vindicating the attitude of organized medicine toward contract practice. —*Minn. Med.*, Dec. 1938.

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The quick, easy method of preparing S.M.A. feedings is unusually simple. A Minute Mix Method Set together with complete directions will be sent Free to physicians on request.



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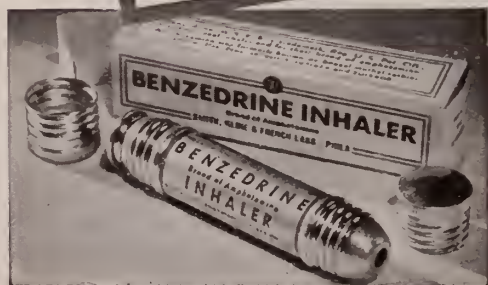
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# Chronic Nasal Congestion

One of the perennially miserable patients whom the physician is called upon to treat every year is the unfortunate individual whose nose is "stopped up all winter" from chronic head colds or sinusitis.

For such cases 'Benzedrine Inhaler' is particularly useful. Its vapor diffuses through the nasal cavity, relieves congestion and aids in establishing ventilation.



Each tube is packed with amphetamine, S. K. F., 0.325 Gm.; oil of lavender, 0.097 Gm.; menthol, 0.032 Gm.

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For shrinking  
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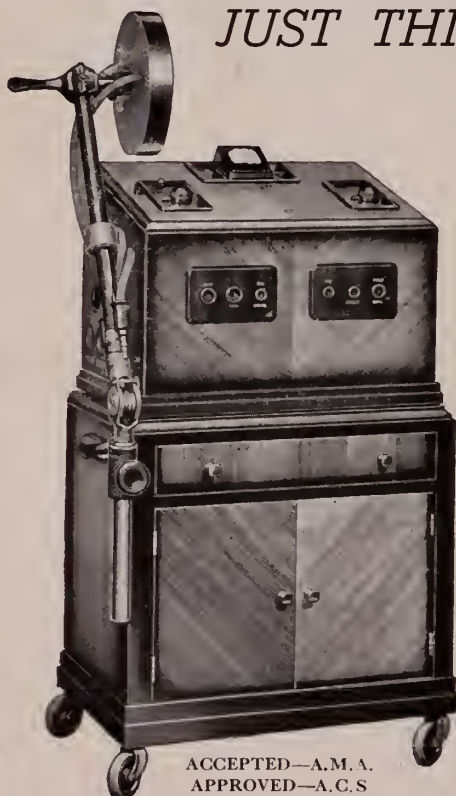
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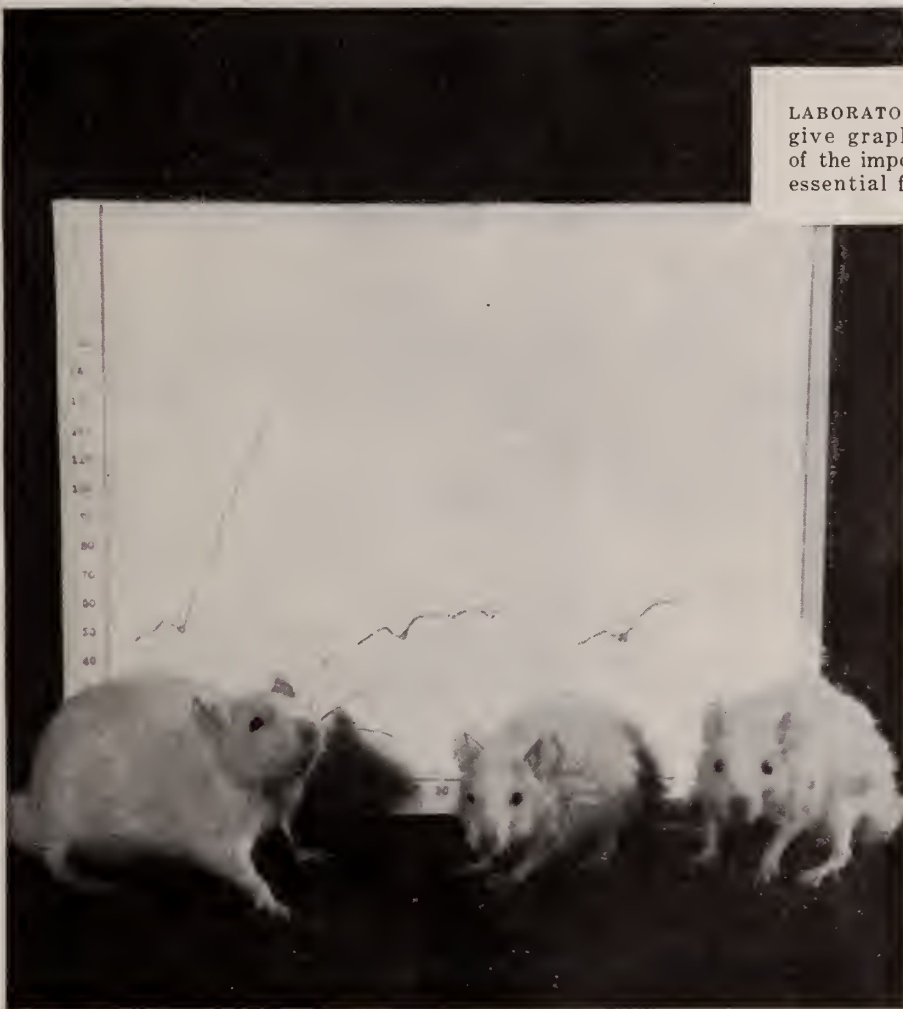


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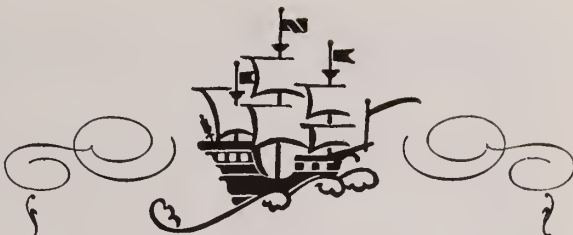
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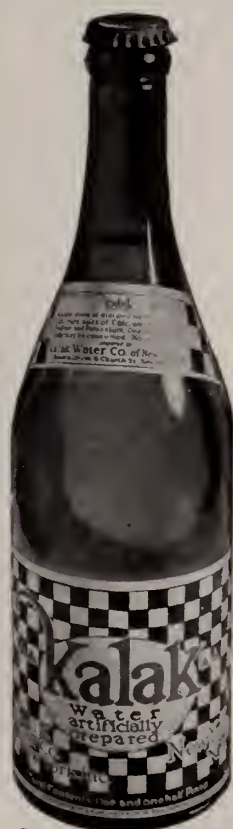
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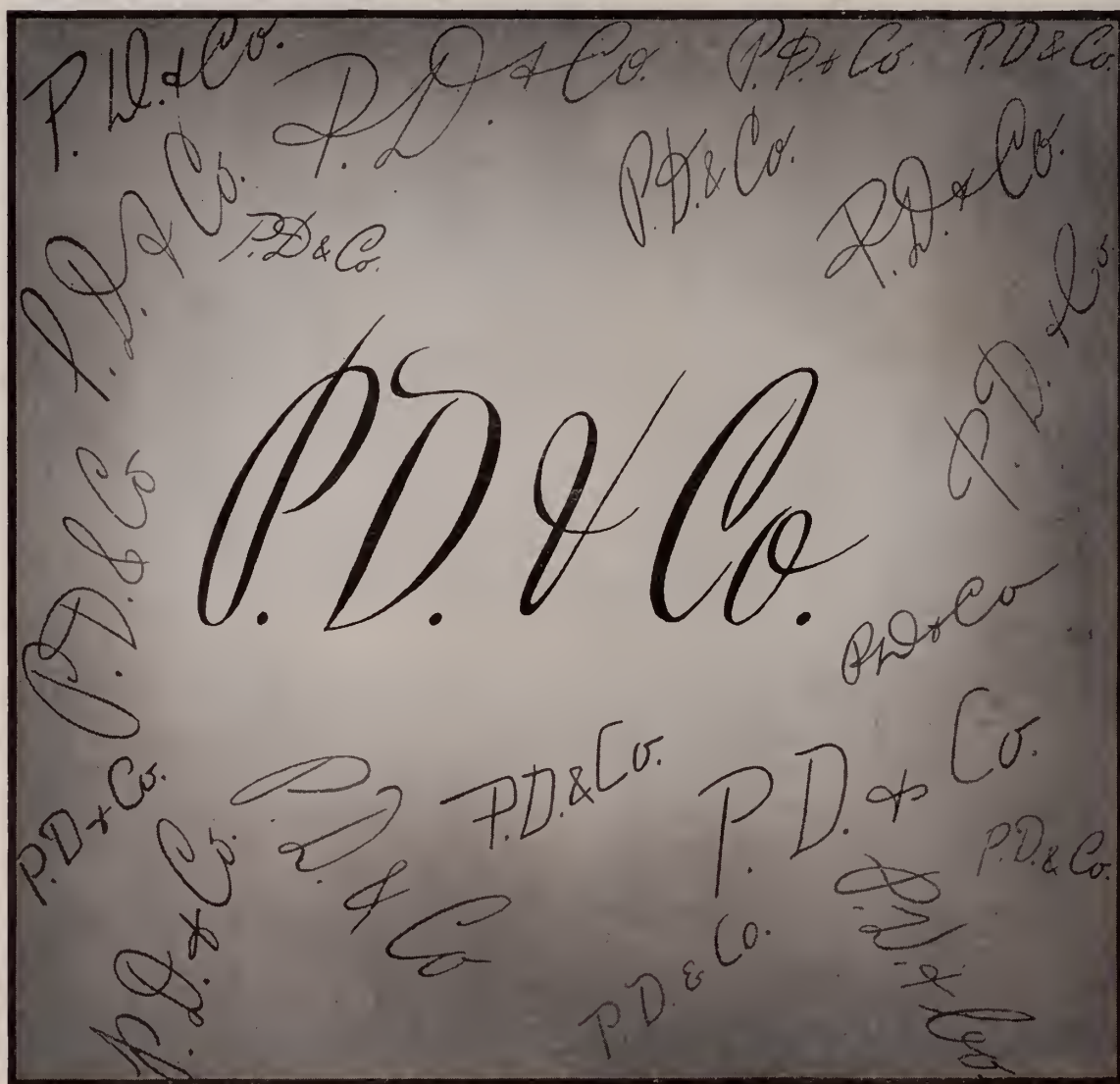
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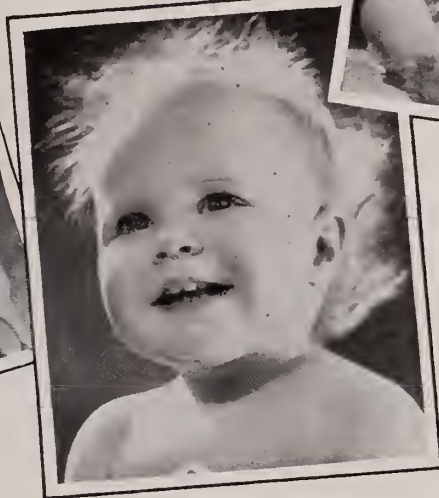
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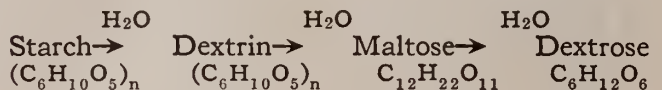
2. Q. What are the Karo equivalents?

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1 oz. wt. . . . .	28 grams
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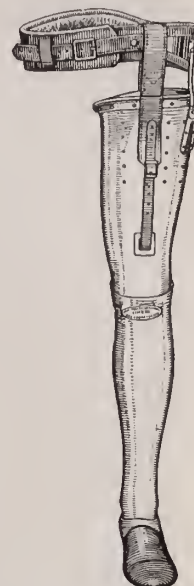


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# JOURNAL *of* The Connecticut State Medical Society

VOL. III.

MARCH, 1939

No. 3

## Perforation of the Urinary Bladder: Report of Case.

K. T. PHILLIPS, M.D.  
Putnam, Conn.

The advantages of supra-pubic drainage over drainage by inlying catheter, in cases of perforation of the bladder, is well illustrated by this case to be reported. Many authors have stressed its value: Berry (1); Cahill (2); Crane and Schenck (3); Keane (4); Hutchinson (5); Stevens and Delzell (6).

CASE REPORT: E. D., a white boy of ten was admitted to the Day Kimball Hospital on May 2, 1938, complaining of pain and bleeding in the anal region. He had fallen from a limb of a tree, landing in such a manner that a stick had entered his rectum through the anus.

He pulled the stick out and ran towards home collapsing on the way. He was brought to the hospital by his parents.

On admission he was bleeding a little from the anal ring and complaining of moderate abdominal pain. His past history had no bearing on his present illness.

Examination revealed a poorly developed and poorly nourished boy appearing to be extremely ill. His pulse was regular at 90, temperature 97 and respirations 18. The abdomen was flat and respiratory movements were entirely thoracic. There was moderate generalized spasm of the abdominal muscles, point tenderness in the lower left quadrant and silence in the abdomen on auscultation. The injury to the anus consisted of two small lacerations in the posterior part, involving mucous membrane and external sphincter.

No digital rectal examination was made because it was felt that it might add to the soiling of the peritoneum which was evident from the other findings. One ounce of urine was obtained by catheter, which had two minute clots of blood in it. Microscopically there were many red blood cells. Other findings were, a trace of albumin and two plus sugar. Other findings contributed nothing.

Preoperative diagnosis was: perforation of the rectum and bladder and peritonitis.

The abdomen was opened, under ether, through a low median incision and an ounce or two of slightly cloudy fluid was found. The small gut seen was reddened slightly. In the vault of the bladder there was a perforating wound

2 c.m. long with three small bits of wood upon its everted edges. The wound in the bladder was enlarged a little and the cavity of the bladder was examined digitally through it and no other foreign bodies were found. The wound of entrance could not be felt by palpation and it was not thought wise to enlarge the opening farther. The rent was sutured with three layers of chromic catgut, each inverting.

The peritoneal surface of the rectum was then carefully examined and it was intact. There was no ecchymosis in the peritoneal reflection from rectum to bladder.

The patient's general condition did not warrant further investigating, although we knew there must be an extra peritoneal opening between the rectum and bladder. No other damage to small or large gut was found and the abdomen was closed with drainage. An inlying catheter was placed into the bladder via urethra and we looked forward to a future repair of the recto-vesical fistula if recovery occurred.

There was a post-operative elevation of temperature and pulse which gradually subsided. Both were normal on the ninth day. Most of the urine drained from the rectum without sphincter control until the fifth day, when this control was regained. On this day he developed a right sided epididymitis which was low grade and not bothersome to the patient.

On the eighth day his condition was encouraging. There was more urine from the catheter and less in his stools.

On the ninth day he had a nose bleed and vomited a large amount of clotted blood. The vomiting opened his operative wound and blood and urine were present on his dressing. After this there was constant urine drainage through the abdominal wound. The catheter was removed when it was evident that ample supra-pubic drainage had established itself. This episode caused an elevation of temperature for six days.

On the eleventh day two ounces of urine were passed by urethra. His red blood count which had dropped to 2,500,000 after the nose bleed, rose to 4,000,000 in two weeks, during which time he was receiving iron and liver by mouth.

On the twenty-first day the recto-vesical fistula closed and normal stools were passed with normal sphincter control. The suprapubic wound stopped draining urine on the thirtieth day and he was discharged on the forty-fourth day.

The abdominal wound was several weeks healing because of the width of the granulating surface. For a month after his discharge he voided very frequently. Since then it gradually improved until he was voiding five or six times a day.

### Conclusions

It is apparent from our experience with this case that extra peritoneal supra-pubic cystostomy, following the repair of the bladder vault, would have accomplished the same good result with less risk to the boy.

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—☆☆—

### MALIGNANT GENITO-URINARY TUMORS CURED ONLY BY EARLY REMOVAL

The only absolute cure for malignant tumors of the genito-urinary tract (kidney, bladder, prostate and ureter) is complete surgical removal of these growths in their early stages, says Henry G. Bugbee, M.D., New York, in *The Journal of the American Medical Association*, for Jan. 28.

"This," the author points out, "can be effected only through an early diagnosis, which may be

difficult because of the late appearance of physical signs and symptoms suggesting a tumor's presence.

"Irradiation in the instance of kidney tumors may be a valuable adjunct but does not take the place of surgery.

"Cancer of the prostate is essentially a fatal disease. Rarely is its complete removal possible.

"A certain amount of encouragement should be derived from the occasional cures obtained from radical surgery in all types of malignant conditions of the urinary tract.

"The watchword should be 'early diagnosis,' with constant emphasis on the necessity of ascertaining the origin of red blood cells in the urine; for only through such means will one be able, in the light of our present knowledge, to substitute methods of cure for palliative treatment in the management of genito-urinary malignant tumors."

—☆☆—

### PROJECTED SECTION ON PROCTOLOGY

In order to increase the value of the State Society to those men who are interested in diseases of the rectum, the formation of a Section on Proctology is being considered. A meeting for organization will be held at the Hotel Taft, New Haven, at four o'clock on May 25 in conjunction with the annual meeting of the State Society at that time.

Several members have manifested keen interest in this project and have signified their intention of attending the meeting. Any members who have not as yet written are urged to write to Dr. Simon B. Kleiner, 41 Trumbull Street, New Haven, signifying their interest in proctology and their intention of affiliating with the section and attending the meeting. If enough replies are received an outstanding rectal surgeon will be invited to address the meeting.

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(SEE PAGE 2.)



# The Differential Diagnosis and Treatment of Ulcerative Colitis†

Z. BERCOVITZ, M.D.\*

New York, New York

The purpose of this paper is to present the practical application of scientific information now available on the differential diagnosis and medical management of ulcerative colitis. Recent scientific investigation has contributed much to our knowledge of this subject. This morning, however, I propose confining my discussion to those aspects of it which will be of greatest practical value in the diagnosis and treatment of ulcerative colitis.

When confronted with a suspected case of chronic ulcerative colitis, the primary duty of the physician is to make sure of his differential diagnosis. If, in spite of conservative therapy, diarrhea, blood, mucus and pus appear persistently in the discharges from the bowel, it is essential for him before arriving at the diagnosis of chronic ulcerative colitis to be able to rule out definitely other pathological conditions, particularly amebic dysentery, bacillary dysentery, acute diarrheas due to irritation from alcohol, etc., and the various conditions such as carcinoma which cause acute diarrhea in older individuals. I shall begin, therefore, with an outline of diagnostic procedures and shall proceed to a consideration of these other conditions which complicate the study of ulcerative colitis. Keeping in mind the practical nature of this discussion, I shall describe incidentally the most effective treatments to be followed in each case.

## Diagnostic Methods

The following simple procedures are indicated for all patients complaining of diarrhea, whether or not this is accompanied by a discharge of blood, mucus, and pus.

### (I) Stool Examination.

Take a small drop of the bowel discharge and emulsify it on a glass slide in normal saline, in Lugol's solution and in methylene blue. The three smears can be made on the same glass

slide, but they should be covered with three separate coverslips. The saline smear is examined for the presence or absence of motile amebae and also for any cells. If the presence of cells is noted, the smear in Lugol's solution should be examined in order to discover whether the cells are cysts of amebae. Since nuclei are visible in the emulsion made with methylene blue, this smear should be examined in order to determine the nature of the cellular exudates in the bowel discharges. The importance to the general practitioner of the presence or absence of cellular exudate lies in the fact that cells appear in the bowel discharge when there is a change in the structure of the bowel mucosa. The mucus secreted by a normal bowel mucosa will be free from cells. But a bowel wall that has suffered pathological changes, either inflammatory or degenerative, causes cells to appear in the discharge. The presence of cells immediately calls for further investigation.

### (II) Sigmoidoscopy.

Sigmoidoscopy is particularly important in cases where cellular exudate is found in the course of microscopic examination of the discharges.

(a) **Preparation for sigmoidoscopy.** This is very important. Sigmoidoscopy should never be undertaken without proper and careful preparation. In order to visualize the mucosa lining of the rectum and sigmoid, it is necessary to clean out the terminal portion of the colon. Two or three tepid saline enemas given about two hours before the scheduled time of sigmoidoscopy is adequate preparation for this purpose. Castor oil should never be given to a patient as a preliminary for medical sigmoidoscopy because the droplets of the castor oil not only remain for a long time, but are also very tenacious and consequently will be found in the discharges or wash-

†Presented at 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.

\*Assistant Clinical Professor, New York Post-Graduate Medical School of Columbia University; Assistant Visiting Physician, Second Cornell Medical Division, Bellevue Hospital, New York.



ings aspirated through the sigmoidoscope. Oil droplets in any microscopic field give rise to much confusion because they may simulate almost anything. Therefore, specimens containing oil droplets should never be considered for examination purposes. If the patient is weak, or if for any other reason it is not desirable to give a series of enemas, preparation should take the form of a gentle colonic irrigation or colonic lavage with tepid normal saline.

(b) **Sedatives.** If the patient is very highly-strung and nervous, it is usually advisable to give him sufficient sedative to make him drowsy, but not sufficient to hinder his co-operation during the sigmoidoscopy. It has been found that if the patient is given some sedative, he is as a rule more co-operative than if he is not given any before the examination. Elixir of luminol (4 cc.) with tincture of belladonna (0.5 cc.) in full dosage is very helpful if given for about 12 hours preceding the sigmoidoscopy. A short-lasting but very effective drug is Seconal. For the average adult a dosage of this drug is grains, one and one-half, given about one-half hour prior to the scheduled examination.

(c) **The Technique of Sigmoidoscopy.** Every time before a sigmoidoscopy is performed, a digital examination should be done. It is most important to gain a knowledge of the exact condition of the bowel wall. Through the simple procedure of digital examination the physician obtains the information he requires, while at the same time he safeguards the patient and eliminates the risk of perforation. It is essential for him to remember that sigmoidoscopy is the passage of a solid instrument into the soft tissue. It involves the serious risk of perforation of the bowel wall, a risk that is all the greater if the patient is weak and the bowel inflamed. With the obturator in place, the sigmoidoscope is inserted into the anus. Then the obturator is immediately removed, and from this point on, the physician should not pass the instrument as much as a single millimeter without seeing exactly where it is going. Passage of the instrument under direct vision means that there is no danger of perforation. Obstructions, such as fecal matter getting in the way or fluid remaining in the loops of the bowel from previous colonic irrigation, can be aspirated with the new sigmoid cannula described by Bercovitz.<sup>1</sup> When

the examination is completed, it is important to write on the hospital chart as well as in the office record the notation that the sigmoidoscope was passed under direct vision. This precaution may save a law suit.

(d) **Findings at Sigmoidoscopy.**

(1) **Normal mucosa** is soft, velvety, and pale pink. It should be remembered that the bowel wall normally has a velvety mucosa which protects the blood vessels, etc.

(2) **Atrophic mucosa** is characterized by the loss of the velvety appearance. Atrophy, which may vary from very slight to rather marked in degree, is present when the capillaries begin to show through and the bowel wall assumes a thin appearance. In this state the blood-vessels appear to be superimposed upon a thin, pale cellophane-like membrane.

(3) **Edema** causes the bowel wall to become swollen, moist and boggy. Inflammation and ulceration may or may not be present.

(4) **Inflammation** is characterized by redness and quite frequently it is associated with edema, giving the bowel wall the appearance of a piece of raw beef. The mucosa is friable and may bleed very readily. Since this edematous and red condition has been observed in normal bowels following undue straining on the part of the patients, its presence should be interpreted with caution.

(5) **Ulcerations** are characterized by areas of various sizes and shapes in which there is a definite break in the continuity of the bowel wall. Polypi and tumors can be recognized readily.

(6) **Lymphogranuloma venerum** is not as rare a condition as it used to be considered. When this is present, the rectum is very granular and thickened so that it assumes a cone-shaped appearance, gaping at the entrance but narrowing down to a small point which will scarcely admit even the tip of the examining finger. To the touch the walls are rough, not unlike a surface of pebbles of various sizes. There is a large amount of muco-purulent discharge and the Frei test practically always gives a positive reaction.

**III Roentgen-Ray Examination.**

The Roentgen-Ray examination of the bowel by means of the barium colon enema is very important. In all cases, even those which are acutely inflamed, castor oil should be used in

order to avoid misinterpretation of shadows which may be found on the Roentgen-Ray films. This procedure is particularly important when dealing with polyposis, carcinoma or narrowing of the lumen, and when studies of the mucosal pattern are indicated. The X-ray films should be interpreted in the light of the clinical history and the general clinical picture.

### **Amebic Dysentery**

Amebic dysentery has an insidious onset, lasting over a period of one or two days, and is characterized by the passage of copious stools. At the end of the first day or two, mucus begins to appear in the stools and after a short time it may be streaked with blood. Occasionally there is a more dramatic onset, but as a general rule the pattern described is followed.

An examination at the bedside of the freshly passed bowel evacuation will show the presence of mucus. A small portion of the mucus should be placed, with the aid of a toothpick, on a warm slide. It should be covered with a cover-slip and examined with the low power objective of an ordinary microscope. If the case is one of amebic dysentery, it will be observed at the first glance that there are very few cells in the field and that those which are present look like pearly-gray dew drops. After watching these cells for a few minutes, it will be noticed that they change in shape. Examined under a high dry objective, the explosive pseudopodia and progressive motility of these cells can be seen. Occasionally, it will be remembered, macrophage cells have a pulsating type of motility, but this is never progressive. If an oil immersion lens is available, in the case of the ameba it will be possible to observe the differentiation between the outer layer of the cell, which comprises the pseudopodia (ectoplasm), and the inner, granular layer of the cytoplasm (endoplasm). An ingested red blood cell may be present, but no other material will be found within the structure of the parasite. As a rule the nucleus is not visualized in *Endameba histolytica* when it is freshly passed and unstained. However, by the simple expedient of examining the freshly passed stool at the bedside, it is possible within the space of a few minutes to make a positive diagnosis of amebic dysentery infection. Every physician who is consulted by a patient complaining of diarrhea should arrange without delay for an examination of the freshly passed stool for evidence of motile amebae.

Cells of tissue origin are to be differentiated from amebae. If a great many cells are found in the mucus placed under the coverslip, it should be suspected that the process is either complicated by a secondary infection of the bowel wall with a corresponding ulcerative colitis or that the case presents some other pathological condition. Some very large cells may be observed in the midst of a heavy cellular exudate. They may have a prominent nucleus and may evidence a certain degree of pulsating activity. This, however, is not a real progressive motility similar to that which is seen in amebae. These cells can thus be identified as the so-called macrophage cells of endothelial origin.

Some bowel discharge should be stained in accordance with Heidenhain's iron hematoxylin technique whenever it is found to contain amebae, in order to give a permanent record of the case and to allow for review, should that be necessary.

### **Treatment of Amebic Dysentery**

Treatment of acute amebic dysentery in which motile amebae are found includes emetine hydrochloride (1 grain daily) given subcutaneously by hypodermic injection, one-half grain morning and evening, the total dosage being 7 grains. Because of the danger of myocardial damage, emetine should never be given intravenously. The total day dose should never be more than 1 grain, and before the administration of each dose the blood pressure and pulse should be checked. A sudden drop in blood pressure with a corresponding increase in the pulse rate is an indication that the emetine should be discontinued. Anayodin may be administered by mouth and the dosage is as follows: one tablet (each one containing 0.25 grams), three times a day, for three days; followed by two tablets, three times a day, for three days; and, finally, three tablets a day until a total of 100 tablets have been taken. In the case of chronic amebiasis, anayodin is the drug to be preferred.

**Carbarsone** has been suggested for both amebic dysentery and bacillary dysentery, but it is not to be recommended owing to the fact that it is an arsenical and, as such, it represents a distinct source of danger.

**Bismuth subnitrate** is one of the most valuable drugs used in the treatment of acute amebic dysentery. Its value was discovered through the excellent work of Deeks and James



in 1924. About a teaspoonful of bismuth subnitrate should be taken three or four times a day. Following an attack of acute amebic dysentery, bismuth subnitrate is taken over a period of about three months. Experience extending over thirteen years has shown that this drug is not constipating, but that on the contrary it has a salutary effect. At the completion of their course of bismuth subnitrate, patients who were previously constipated have found that they have a single daily evacuation unattended by distress, and without the use of laxatives. It is necessary to insist that the patient be given the subnitrate of bismuth and not the subcarbonate or the subgallate. At no time should rectal or colonic medication be given because of the danger of perforation.

### Bacillary Dysentery

Bacillary dysentery may be caused by a member of the Shiga, Flexner, or Sonne group of organisms. It frequently occurs in epidemics. It is characterized by a sudden, dramatic onset, and by frequent bowel movements, numbering from 20 to 100 daily, in which there is severe tenesmus and straining. The movements are small in amount; they are sticky, and have an admixture of blood and pus.

The pathological process is a necrosis of the bowel mucosa caused by the circulating toxin engendered by the organism. The discharges represent sloughs of this necrotic bowel wall. The symptom of tenesmus is important because it indicates involvement of the terminal portion of the bowel, including the rectum and sigmoid, and it applies not only to bacillary dysentery but also to any other bowel involvement.

Microscopic examination of the freshly passed bowel discharges shows the presence of myriads of cells of all shapes, sizes and descriptions. The technique for examining this type of discharge, as well as all other types which occur in any diarrheal condition, includes a preliminary examination of freshly passed bowel discharge without any stain. Following this, a drop of Loeffler's methylene blue, mixed with the matter to be examined and covered with a coverslip, gives a preparation which can be very readily examined. In this type of preparation the cell outline may be clearly seen and the nuclei appear as rings of beads within the cell.

It is possible to determine whether polymorphonuclear leucocytes are segmented or young

forms. In some instances cells appear to have 2 or 3 nuclei. These are usually segmented polymorphonuclear leucocytes. Epithelial cells appear in various sizes and shapes, and the nuclei are prominent and clearly visualized as a result of the methylene blue. In cases of bacillary dysentery, giant macrophage cells are very prominent. Many of them are vacuolated and contain ingested necrotic material.

To prepare cultures for bacillary dysentery, it is necessary to inoculate freshly passed material immediately upon freshly prepared Endo's medium. Failure to follow these directions minutely may result in a negative culture. It should be noted, however, that as a rule cultures for bacillary dysentery are unsatisfactory, and that after the first few days of the disease it is rather rare to obtain a positive culture.

### Treatment of Bacillary Dysentery

The treatment of bacillary dysentery is along two lines — specific therapy, and general supportive measures. *Polyvalent antiserum* is administered in large doses. As the serum is usually made up with horse serum, it is essential to determine the patient's sensitivity to it before it is administered. But even when this precaution has been taken, in many cases a severe serum reaction may follow immediately, or later, because it is necessary to use about 100 cc. of polyvalent serum to obtain satisfactory results. The serum may be given intramuscularly or intravenously but when the latter method is used, it should be given very slowly or mixed with saline and administered by the drop method. In any event, the danger of serum reaction is very great.

*Sodium sulphate* or *magnesium sulphate*, administered as crystals, is almost as specific as polyvalent serum, and has the advantage that there is no serum reaction to follow. This method of therapy has been established for well over a hundred years and has not only stood the test of time but has also won the approval of many competent observers throughout the world. Among those whose names may be mentioned in this connection are authorities such as Manson-Bahr, Wenyon, Douville, and the late Francis W. O'Connor, Professor of Tropical Medicine at Columbia University, who spoke on this platform three years ago.

*Sodium sulphate* is administered to adults usually in doses of one tablespoonful. It may be given as a single morning dose, or it may be given



in divided doses throughout the day. Within twenty-four hours after the administration of sodium sulphate or magnesium sulphate, it will be noticed that the stool becomes more copious, that there is less straining and tenesmus, and that the general condition of the patient shows improvement. A tablespoonful of the salts should be continued for two days, after which the dose may be decreased to three teaspoonfuls for two or three days, then two teaspoonfuls, and finally, one teaspoonful. By this time it will be noticed that the stools are soft, mushy and feculent in character, and that practically all the blood and pus will have disappeared.

**Chemotherapy.** From time to time, various drugs have been suggested that would sterilize the bowel. Anayodin, which is used in the treatment of amebic dysentery, has been found somewhat effective in about four or five per cent of the cases in which it has been administered.

### General Supportive Measures.

(1) **Glucose Infusions.** Five per cent glucose in normal saline is administered intravenously and may be given in amounts of 2,000 to 3,000 cc. daily, depending upon physique, weight and size of the patient.

(2) **Blood Transfusions.** Early in the treatment of bacillary dysentery, blood transfusions should be given. Whole blood is probably the best therapeutic measure we have at our command today. Every three or four days, 500 cc. should be administered to the patient by the direct method. The blood and glucose in normal saline can be administered together in the course of treatment.

(3) **Dietary Management.** The diet in bacillary dysentery should be high protein and low residue. Milk is to be avoided since experience has shown that patients do not make satisfactory progress when it is included in their diets. Dietary management will be discussed in detail under chronic ulcerative colitis.

(4) **Sedation.** In bacillary dysentery, rest is of vital importance to the patient. Codine in full dosage, morphine or pantopon may be administered. Luminal, to which sodium bromide and possibly some tincture of belladonna have been added, is valuable if the patient is suffering unduly. One of my favorite prescriptions is as follows:

Rx: Tincture belladonna	8.0
Sodium bromide	10.0
Elixir luminal q. s. ad	60.0

M. Sig: one teaspoon q 4 hours

Paregoric is of doubtful value in bacillary dysentery. While no harm will result from its use, it rarely does good when there is a definite breakdown in the bowel mucosa. For the severe tenesmus, a suppository made up as follows is helpful:

Rx: Epinephrin, 1-1000	3.0
Anesthesin	3.0
Cocoa butter q. s. ad.	20.0

M. Fiat Suppositories No. X

Sig: one q 4 hours p. r. n.

If these measures fail to give the patient sufficient rest, morphine is indicated. It is good therapy to use morphine under such conditions because rest and quiet sleep are most valuable to the patient.

In recent practice, methods have been devised that eliminate much of the drain upon the patient's vitality and consequently enable him to obtain as much rest as possible. Instead of the constant use of the bedpan, it has become customary to use a sort of diaper with absorbent cellulose composition pads. The patient is encouraged to allow the bowels to evacuate into this diaper, and is told that it has been devised to save his strength as much as possible.

It may be well to call attention to the effect which straining to move the bowels has upon the bowel mucosa. It is a common observation and can be easily demonstrated through the sigmoidoscope that when a patient with a normal (pale pink, soft velvety) bowel mucosa strains, redness, swelling, edema immediately develops, and in some cases the bowel has been seen to bleed right under the eye of the observer. As soon as the patient relaxes, these abnormal conditions recede. It requires no stretch of the imagination to see the effect which constant straining and tenesmus has upon the unfortunate victim of bacillary dysentery. This also applies to the patient with chronic ulcerative colitis.

### Acute Diarrhea Due to Irritation

The consumption of alcoholic drinks, of unusual foods, or of those which have been partly decomposed, is the chief cause of irritation leading to acute diarrhea. In these cases the diagnosis is relatively simple. A drop of the bowel discharge should be examined under the micro-

scope. If no cells are found, the indication is that there has been no breakdown in the bowel mucosa.

### Treatment

A dose of saline laxative or of castor oil should be followed by the sedative mixture given under bacillary dysentery. A simple non-irritating diet and rest for one or two days should restore the patient to health.

Bismuth subnitrate, which is used in the treatment of amebic dysentery, is useful for this condition also. If much pain is present, it might be well to add some belladonna. A good prescription is as follows:

Rx: Extract of belladonna 0.20 (or 0.30)

Bismuth subnitrate 80.0

M. Fiat Charta No. XX

Sig: one powder q 4 hours

Of course, if a prescription of this type were used, the belladonna should be omitted from the sedative mixture. (p. 10)

These general measures, together with rest in bed in a cool location, are indicated for the acutely irritative type of diarrhea which is likely to occur in the summer months following the consumption of ice cold drinks on very hot days when the individual is overheated.

### The Acute Diarrhea of Older Individuals

Not infrequently an acute diarrhea develops in older people who previously have had no bowel complaints whatever. In all such cases the physician must consider the possibility of carcinoma, and must determine whether or not it is present. He should make a careful microscopic examination of the stools and should look particularly for cells. If cells are present, they can be seen clearly in a smear made with methylene blue. Their presence is indicative of pathological change in the bowel wall. The patient should have the benefit of a digital examination, sigmoidoscopy, and a barium colon enema. In many cases the carcinoma is very small, lying behind the recto-sigmoid fold and just beyond the region of the examining finger. If nothing is found on digital examination, sigmoidoscopy should be performed after the patient has been prepared according to the technique already indicated. If the lesion is not found at sigmoidoscopy, a barium colon enema should be made. The preparation of the patient for this enema will be described under the heading of chronic ulcerative colitis.

While carcinoma of the bowel is one of the most common causes of diarrhea in individuals who have reached the carcinoma age, it is not the only cause. Diarrhea may attack elderly individuals, especially those who are debilitated as a result of some prolonged illness. Up to that point they may have reached old age in relative comfort. In many of these persons, there will be a sudden onset of a profuse, watery diarrhea which, if not treated immediately, may be the immediate cause of death. Examination of their stools will often give negative results. But it may be necessary to use heroic measures in order to save their lives. (1) Withhold all food for 24 to 36 hours. (2) Prescribe a saline laxative, as in the case of bacillary dysentery, (3) Follow the supportive measures indicated for bacillary dysentery, with particular references to the glucose and blood transfusions. In addition to 2,000 cc. of glucose in saline, it may be necessary to give a blood transfusion of 500 cc. every day or every other day. (4) Start diet with sips of tea; gradually increase the amount of weak tea. Rice gruel or barley gruel can then be given. Give clear consommé at first, and later add well-boiled rice to it or a baked potato. For this type of patient, the sedative mixture given under bacillary dysentery may be given. As a rule bismuth and kaolin should be avoided since they tend to upset the stomach.

### Chronic Ulcerative Colitis

Several important bowel conditions confront the physician who is dealing with cases of chronic ulcerative colitis.

In the first place, carcinoma of the bowel may be found in young individuals. It frequently follows in the wake of a chronic ulcerative colitis in which there has been hyperplasia of the bowel mucosa with polypoid formation. In the process of degeneration, this may develop into carcinoma. Re-examination with the sigmoidoscope and the Roentgen-ray with a barium colon enema must be done in order to understand the case fully and to discover whether malignancy is present or not. Malignant degenerations constitute a surgical problem which must be met at the earliest possible moment.

Lymphogranuloma venereum may appear as a rectal stricture in the male as well as in the female. It may also occur with the clinical picture of a so-called chronic ulcerative colitis which is resistant to the ordinary therapeutic



measures. A Frei test should be made for a patient of this type in order to demonstrate this virus. The Frei antigen is now available in mouse brain emulsion, and is it also available with mouse brain control. (Lederle & Company product). For the test 0.1 cc. of antigen is required, but it must be carefully controlled with the virus free mouse brain emulsion. The test is read at 72 hours, and again at one week and two weeks. An area of redness, with infiltration of at least seven millimeters in diameter, and at times with pustule formation, is indicative of a positive reaction especially if this persists for several days after the original inoculation. These cases are treated with Frei antigen.

**Fistula.** A recto-anal fistula will cause the discharge of blood and pus, and at times it will also cause a persistent diarrhea. In these cases the patient must receive surgical treatment.

**Vitamin C Deficiency.** In a large percentage of cases of chronic ulcerative colitis, the simple capillary fragility test will show that Vitamin C has failed to be absorbed and stored. This condition is due to the fact that many of the so-called standard ulcerative colitis diets are deficient in foods which contain Vitamin C. If Vitamin C is added to the diet, it will be found that many patients will improve very rapidly and that there will be a definite decrease in the amount of blood. In some cases the diarrhea seems to improve also. It is important for the physician to study the relationship of Vitamin C to each case of chronic ulcerative colitis. Vitamin C deficiency is treated with cevitamic acid, 300 milligrams daily by mouth.

### Medical Management of Chronic Ulcerative Colitis

When all other possible pathological conditions have been ruled out, the physician can proceed safely with the treatment for chronic ulcerative colitis. The patient may have diarrhea and may have mucus, blood, and pus, and the bowel wall may be inflamed and edematous. Ulcers, commencing as minute breaks in the tissue, may begin to invade the tissues beneath the surface and at the same time may spread over a wide area of the bowel wall. But chronic ulcerative colitis must be treated as a systemic problem and not merely in the light of a local infection of the bowel. It should be recognized at the outset that the resistance of the patient is of first im-

portance. Since it is not possible to kill the bacteria which set up the infection without destroying tissues as well, it is highly important to build up the general condition of the patient. With the exception of the bacillary dysentery group of organisms, bacteria do relatively little damage until the bowel wall is weakened, and consequently therapeutic measures should be directed definitely towards reestablishing resistance. At the same time, careful thought must be given to the matter of foci infections, to nutrition, and to the comfort and well-being of the patient.

(1) **Sedatives** are important and should be used as outlined under bacillary dysentery.

(2) **Supportive measures**, especially blood transfusions and the use of glucose infusions constitute the best therapeutic measures known today. A blood transfusion of 500 cc. by the direct method is indicated in every case, and this may be repeated every 3 or 4 days according to the condition of the patient.

(3) **Dietary Measures.** Chronic ulcerative colitis cases should have a high protein and low residue diet, well balanced with vitamins. Enough starches should be added, however, to maintain the patient's caloric requirements. Scraped chopped beef, which may be given twice a day, is definitely indicated. It will be found that the patient's strength can be maintained better under this regime than if gruels and starchy substances only are given. Red meat should be given when the tongue is smooth and glassy, the gums bleeding and spongy, when free hydrochloric acid is lacking and the patient is anemic. Milk should not be given, although butter milk is acceptable. Pureed vegetables are indicated, and the list should include green vegetables as well as the baked potatoes. Gas-forming vegetables such as onions, etc., should be avoided. All diets should be served in the most attractive manner possible. Small amounts will tempt the patient more readily than large portions. The chronic ulcerative colitis patient is nauseated and certainly not hungry, and should therefore not be confronted with a large tray containing all kinds of food. It is much better to serve one article of food alone. Most patients will be discouraged when given many things to eat, whereas they will attempt to eat the one item offered them.



### Special Diet List

*Important Notes: Read and Follow Exactly.*

1. The object of this diet is to provide foods which will be easily digested, readily absorbed and leave a minimum of residue which might be irritating to the bowel.

2. Your absolute cooperation in the matter of diet is vital for the proper handling of your condition.

3. Make no changes without consultation.  
*Eat only the foods listed below.*

4. Please bring this diet list with you at each office visit.

5. Eat some of the following food at 10 A.M., 4 P.M., and at bed time: Bouillon, chocolate flavored vitavose (Squibb), eggnog, fruit juice — Holland rusk, toasted white bread, zweibach.

#### Only the Foods Listed Below May Be Eaten

*Beverages* — Bovril, cocoa, coffee, cream, milk, weak tea, vegex, vichy. (Fruit juices as listed.)

*Bread stuffs* — Bread sticks, dry white toast, Holland rusk, melba toast, zweibach.

*Cereals* — Cream of wheat, farina, hominy, strained oatmeal.

*Desserts* — Cornstarch pudding, custards, D-zerto, ice cream (without nuts or seeds) jello junkets, Knox gelatin, royal pudding.

*Eggs* — Poached, soft boiled, scrambled in double boiler; or used in eggnogs or custards.

*Fruits* — Pureed or canned; grapefruit (canned or fresh without membrane), peaches, pears, bananas.

*Fruit Juice* — Grapefruit juice, orange juice, pineapple juice, tomato juice.

*Meats* — Lean bacon, roast beef, scraped chopped beef, heart (calves, beef, lamb) lamb chops broiled, roast lamb, filet of sole broiled or boiled, boiled tongue, boiled ham and calves liver.

*Soups* — Bouillon, half milk and half cream with addition of pureed vegetables, strained vegetable soup in which no onion or other gas-forming vegetable has been cooked (made from only vegetables listed below), lentils and split peas.

*Starches* — Baked potato without the skin, mashed or other soft forms of potato, rice well cooked with plenty of water till soft, macaroni, and spaghetti.

*Vegetables* — All to be pureed: Asparagus, beets, beet greens, carrots, peas, spinach, squash, string beans, swiss chard, broccoli.

#### Do Not TAKE the Following

*Alcohol* — No alcohol in any form.

*Cathartics* — No cathartics or laxatives in any form.

*Meats* — No cured meats; no fried meats; no corned beef, dried beef, ham, kidney, pork, shell fish, or veal.

*Pastry* — No rich pastries.

*Spice* — No highly spiced or highly seasoned foods.

*Vegetables* — No vegetable which has not been pureed; no artichoke, brussel sprouts, cabbage, cauliflower, corn, cucumbers, lettuce, lima beans, onions, peppers, radishes, sauerkraut, scallions, tomatoes, turnips, watercress.

(4) **Beverages.** Alcohol must be eliminated in every case of chronic ulcerative colitis. Even medications containing alcohol prove injurious to the patient. Beverages may include tea, malted milk or butter milk.

It is often desirable to give the patient nourishment between meals. A nourishing drink may be made as follows: whip one tablespoonful of malted milk powder into about 3 or 4 ounces of water; beat in one or two eggs when the powder is thoroughly mixed, and serve with a scoop of vanilla ice cream. Another means of giving light nourishment is by adding two or three ounces of pressed beef juice to beef broth. This should be served either clear or else with some well cooked rice.

Tomato juice may be given with one meal. It should be taken with food, and not on an empty stomach. When served first of all, the patient should be given tablespoonful amounts, and these can be built up to 2 or 3 ounces with each meal. Many patients are able to do well with tomato juice when given in this way, whereas they could not manage it if given in a large quantity on an empty stomach. Orange juice is more likely to cause distress than tomato juice.

(5) **Liver extract** may be given by injection in amounts of 3 cc. daily intramuscularly. The old liver extract concentrates are better for these patients than the more highly refined new products that are on the market today. The response to liver extract injections has been very favorable. Although these injections have to be

kept up over a considerable period of time, the patient soon responds to the treatment. His appetite improves; the glassy smooth tongue disappears; there is a return of the free hydrochloric acid, and in general the condition of the patient is definitely more satisfactory.

(6) **Vitamin B.** is very important in these cases and may be administered either by mouth or by injection.

(7) **Histidine hydrochloride.** In March 1937, Bercovitz and Fuller reported the use of histidine hydrochloride in the treatment of chronic ulcerative colitis. They found that in a large percentage of cases the patients showed improvement and that their recovery was uneventful. To date, 25 cases have been treated with histidine hydrochloride and the results are sufficiently encouraging to warrant further use of this method of therapy. It is administered by injection, 5 cc. of 4 per cent solution being given intramuscularly daily. The average course includes about 40 or 50 injections. The beneficial influence is not apparent until at least 20 injections have been given. The bowel mucosa is studied at weekly intervals in an effort to follow the changes which occur. Under the treatment with histidine hydrochloride, it has been observed that the hyperplastic, inflamed, and edematous areas regain their normal appearance, while ulcerations show evidence of granulation and healing. Marked improvement occurs; the bowel movements become less frequent in number; while tenesmus, diarrhea, blood, mucus, and pus disappear from the stools. Some of these patients have been followed for two years, and their bowel condition has remained perfectly well in spite of unfavorable living conditions and repeated attacks of influenza.

(8) **Vaccine therapy.** In a certain percentage of cases, treatment with specific vaccines seems to be of value and the patients apparently improve. However, vaccines from the bowel flora must be administered with great caution in order to avoid a very severe reaction in the patient.

When all is said and done, remember that you are treating a patient and not bacteria, amebae, vitamins, or even bowels. What you do for the patient, you do for the bowel.

565 Park Avenue.

## SYMPOSIUM ON CANCER OF PROSTATE

### Association of Connecticut Tumor Clinic

New Haven Hospital Farnham Amphitheater  
March 10, 1939, 4:00 P.M.

### PROGRAM

(Papers limited to 5 minutes)

#### 1. Report of Cancer of the Prostate

Dr. Charles Y. Bidgood,  
Hartford Hospital, Hartford, Conn.

Dr. Chris H. Neuswanger,  
Waterbury Hospital, Waterbury, Conn.

Dr. Halford B. Kneale,  
Bridgeport Hospital, Bridgeport, Conn.

Dr. Edward J. Ottenheimer,  
Windham Community Hospital, Willimantic, Conn.

Dr. W. Rodgers Foote,  
New Haven Hospital, New Haven, Conn.

Dr. Dwight Wilson,  
New Haven Hospital, New Haven, Conn.

#### 2. Pathological Report on Cancer of Prostate

Dr. Robert Tennant,  
New Haven Hospital, New Haven, Conn.

#### 3. Incidence of Cancer of the Prostate in the State of Connecticut

Dr. John H. Watkins,  
Department of Public Health, Yale School of Medicine, New Haven, Conn.

#### 4. How Cancer of the Prostate Grows

Dr. Edwin Lawrence,  
New Haven Hospital, New Haven, Conn.

#### 5. Diagnosis of Cancer of the Prostate

Dr. Ralph H. Jenkins,  
New Haven Hospital, New Haven, Conn.

#### 6. Diagnosis and Treatment with X-ray

Dr. Hugh Wilson,  
New Haven Hospital, New Haven, Conn.

#### 7. Surgical Treatment of Cancer of the Prostate

Dr. Clyde L. Deming,  
New Haven Hospital, New Haven, Conn.

#### 8. General Discussion

All Physicians Cordially Invited.



# Presidents' Proscenium

## Chiropractic Menace Defeated

L. W. BORTREE, M.D.\*

Colorado Springs, Colorado

The Colorado State Medical Society, having in the past year had to combat one of the most malevolent attacks yet made on health legislation, feels it advisable to let other societies know the possible dangers which they too might face.

The medical practice act of Colorado provides for an examining board which is now composed of six doctors of medicine and three osteopaths. This board issues the same license to both medical men and osteopaths, based on an examination which includes no therapeutics. It formerly issued a limited license to chiropractors, but, in 1931, there was enacted a law providing for a separate chiropractic board. So there are now two State Boards issuing licenses to practice the healing art in Colorado.

For many years the Colorado State Medical Society had striven to secure the enactment of a basic science law. Such a law was finally passed in 1937. The osteopathic profession accepted this law as satisfactory but the chiropractors have remained bitterly resentful of its restrictions.

Realizing that all professions connected with the healing art have certain mutual interests that should be recognized and coordinated, there was organized early in 1937 the Colorado Inter-Professional Council, which consists of one representative each from the following organizations: Dental Association, Medical Society, Veterinary Association, Pharmaceutical Association, Nurses Association, Insurance Association and Hospital Association. This has proven a very valuable medium for integrating the activities of the organizations chiefly concerned with maintaining health standards in the State.

One year ago a group of Colorado chiropractors started circulating petitions to place on the ballot the following amendment:

"Be it enacted by the people of the State of Colorado:

The Constitution of the State of Colorado is hereby amended to include therein the following article:

Section 1. No person shall be denied the exclusive right to choose his own State licensed system of healing and doctor for State required examinations, or for therapeutic services in connection with State Compensation or other insurance benefits, nor to choose his own State licensed system of healing and to have such service rendered him while an inmate, patient or charge of tax-supported or partially tax-supported corrective, therapeutic, eleemosynary or other public institution in the State.

Section 2. No profession recognized by the State shall be denied the exclusive right to examine, license and regulate the practice of its own members through its own legally constituted board or authority.

Section 3. This amendment shall be self-executing and the general assembly shall enact such regulatory measures as are necessary to carry out its purposes."

As one reads the proposed law the first impression is that it is a very reasonable provision and the reaction of the average uninformed voter would have been almost universally for its adoption. Thoughtful scrutiny reveals two major menaces to good health. Section one would open every hospital in the state to any irregular practitioner because all hospitals are partially tax supported, inasmuch as they care for indigent persons or employees insured under the State Compensation Law. Had such a measure passed, it would have been impossible to maintain proper hospital standards. Furthermore, this section would have caused wide spread con-

\*President, Colorado State Medical Society.



fusion in all compensation and accident cases and would have had an adverse effect upon health, accident and compensation insurance.

The main objection to the proposed amendment comes from section two, which would nullify all present statutes providing for the examination, licensure and regulation of every profession recognized by the state. Such an act would have caused chaos in all professions. Another menace was the fact that this was an amendment to the State Constitution and would have precluded any future action by the legislature in any way conflicting with its provisions.

For months the chiropractors conducted an intensive campaign. In their advertising program, they urged the passing of this so-called "health freedom amendment" to repeal the basic science act, to open the hospitals and asylums and to allow freedom of choice of healers to all citizens. By so doing, they managed to work up a tremendous amount of sympathy for the measure.

As is customary, the medical profession took the lead in opposition to the amendment through an advertising agency which managed the campaign. Three publicity mediums were used. Every radio station in the State was scheduled for a certain amount of time, usually five minute periods. Most radio presentations were made by individuals, not of the medical profession and talks were prepared for members of all affected professions and distributed to key-men in each locality for assignment.

The second medium was newspaper advertising. All advertisements were prepared by the advertising agency, and sent to every newspaper which had sufficient coverage to warrant its use. The advertisements appeared weekly for the last three weeks prior to election and were largely simple direct statements.

The third type of advertising medium was pamphlets. The first was a rather elaborate brochure giving in detail all possible ill effects of the measure if enacted. A second was a slip

asking people to vote NO on this amendment and list five simple reasons for so doing. This was of a size convenient to go into an ordinary business envelope and was widely distributed by individual physicians and other organizations as an enclosure in their regular mailing. The State Nurses' Association, in addition, put out somewhat similar literature stressing the effect upon hospitals and nurses. This was done in collaboration with the medical societies' organization but as an individual activity of the State Nurses' Association.

During the entire campaign, we had the active and efficient support of the Colorado Osteopathic Association and even some of the chiropractors. The osteopaths conducted their own radio and newspaper campaign and also every osteopathic physician in the state sent out individual letters to his clientele urging the defeat of the act.

In addition to these three methods of publicity, a speaker's bureau was organized by each County Society and efforts were made to contact every organization which would have a meeting previous to election. Each was offered a speaker and many accepted. The speakers were provided with proper information or with prepared talks and undoubtedly influenced a large number of votes. The students of the State Medical School organized an especially efficient speakers' bureau which functioned mainly in Denver.

The contral campaign committee of the State Medical Society contacted as many organizations in the state as possible, explained the situation to them and asked for an expression of opinion. Before election day, over eighty organizations, largely with state wide membership, had gone on record opposing the measure. Throughout the campaign a consistent effort was made to keep the arguments upon a high plane and to avoid personalities.

As a result of the efforts of the medical profession and its allies, the proposed measure was

*(Continued on page 154)*

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# Association of Connecticut Tumor Clinics

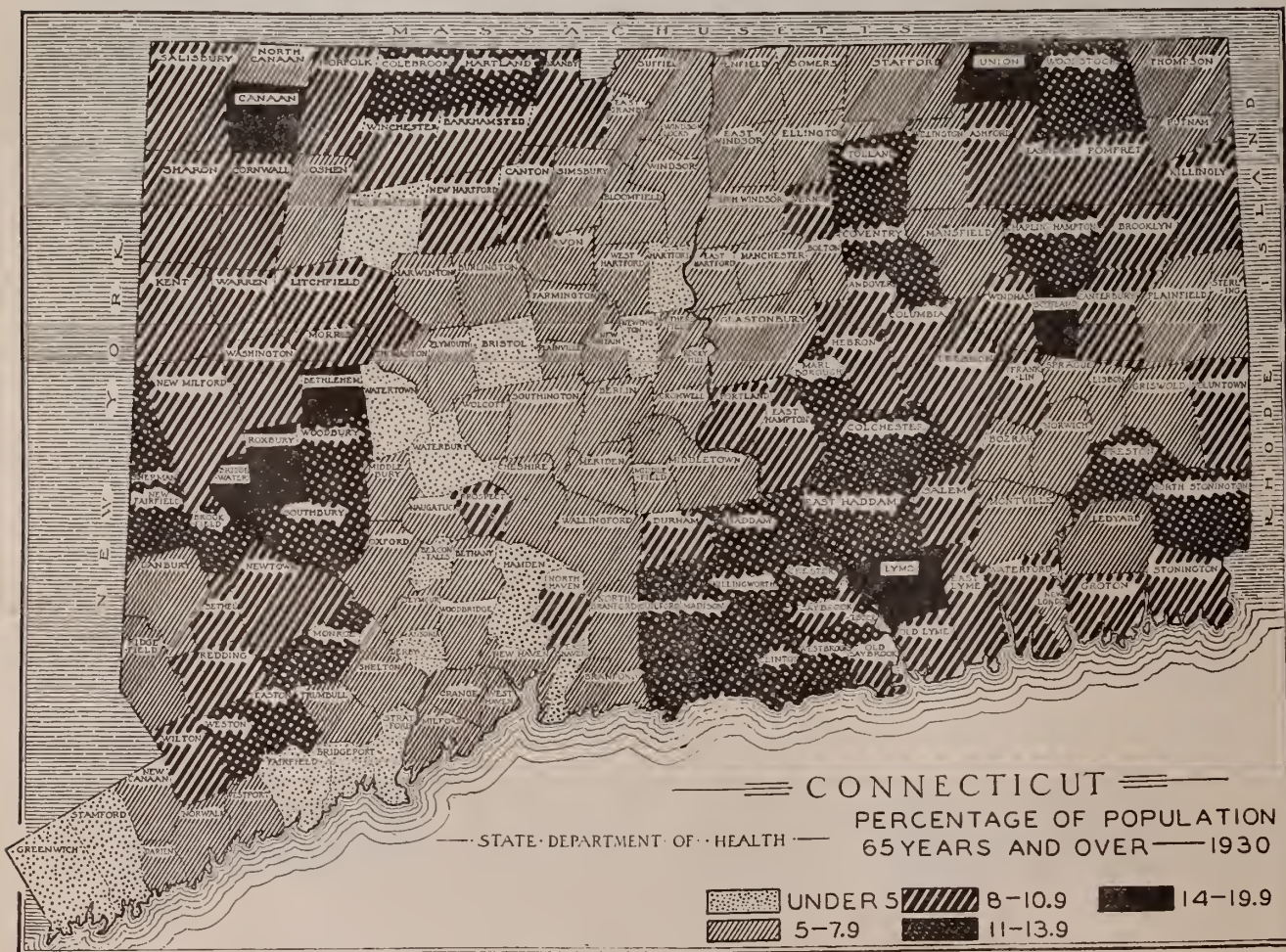
A Symposium Presented at the Tenth Meeting  
of the Association held at Windham  
Community Memorial Hospital  
Willimantic, December 8, 1938

DRS. KENNETH K. KINNEY, EDWARD J. OTTENHEIMER, RICHARD SHEA  
BRAE RAFFERTY and MR. WILLIAM B. SWEENEY

## PART I — INTRODUCTION Kenneth K. Kinney, M.D.

We are presenting to the Association of Tumor Clinics a statistical study of the cancer situation in the Windham Community Hospital for the past ten years. We affirm at the outset that the

number of cases in this series is too small to be of any statistical value, so far as incidence, operative mortality, or five-year end results are concerned. The only conclusion, therefore, we feel justified in drawing from this study is that it does depict as accurately as possible the cancer





problem, good, bad, and indifferent, in a relatively rural area over a ten-year period.

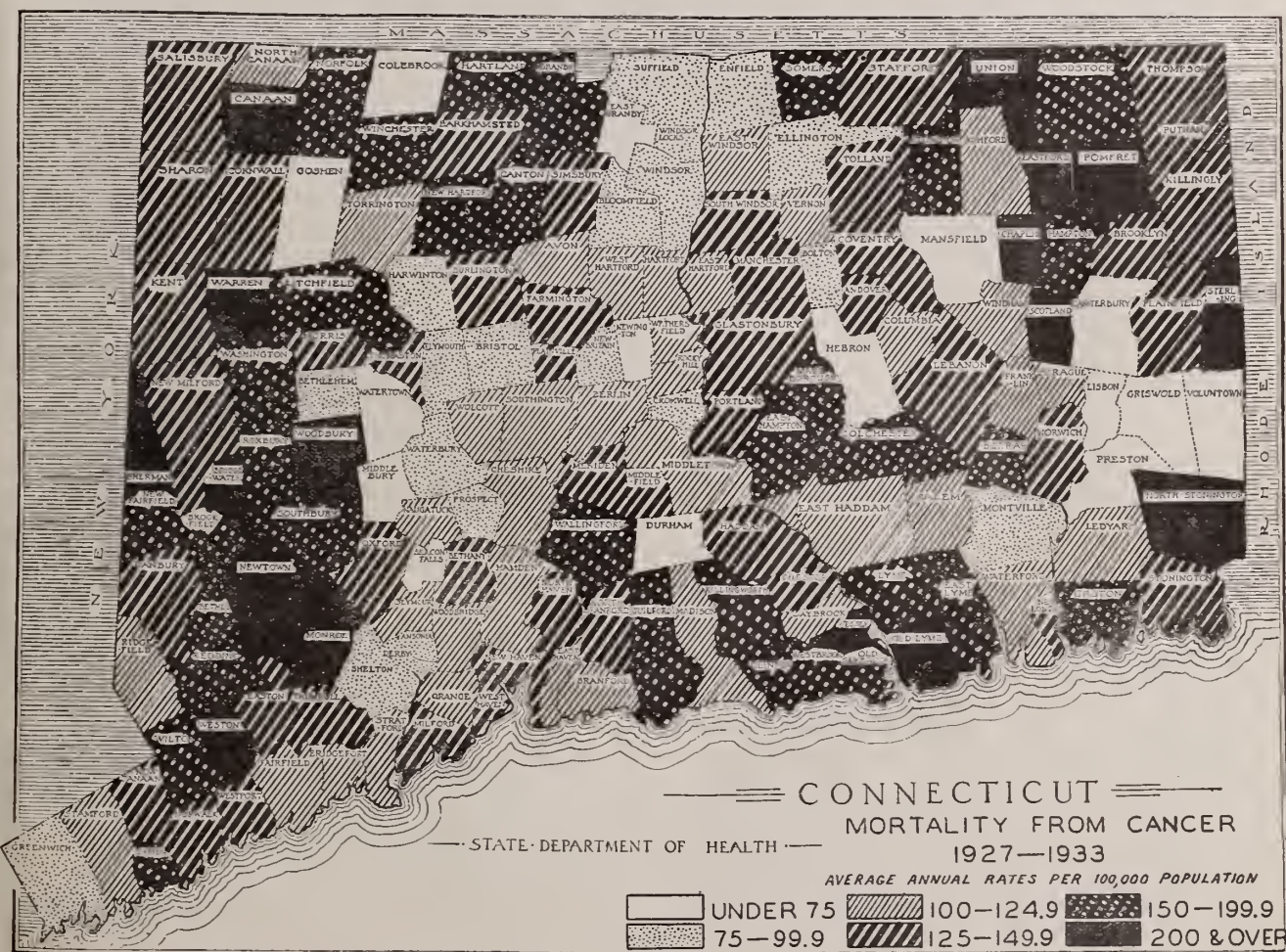
We feel that the cancer statistics of many larger institutions that draw cancer patients from communities not in their direct hospital area, do not, consequently reflect the true cancer picture of their communities. In our case, however, we know definitely from our vital statistics that 86% of the total cancer deaths in our hospital community have been treated in our institution. A study of our hospital records, therefore, should give us a true concept of the entire cancer problem in this community.

The Windham Community Memorial Hospital is a 90-bed, voluntary, non-profit corporation, with modern buildings, equipment, and diagnostic facilities, including deep X-ray therapy and 70 milligrams of radium. It serves one city, Willimantic, and 16 adjoining towns. Willimantic is a small industrial city (textiles), of approximately 14,000 people. There are about

18,000 in the surrounding towns which cover an area of 20 miles square, making a total of 32,000. Two towns only, exclusive of Windham, have resident physicians.

The diagram first shows the age distribution of the population of the state of Connecticut, with the younger age groups in the more industrialized urban areas in the central part of the state. The percentage of population over 65 in our hospital area is 10, whereas the average for the state is 5.5.

This diagram shows the percentage of cancer deaths in the towns of the state. It is observed that the percentage of cancer deaths is greatest in the towns which have the greatest proportion of old people. It is 9% for the city of Willimantic, and 11% for the surrounding towns. For the United States as a whole, it is a little over 8%. The cancer death rate in our community is 21.5 per 10,000 people and 18.5 of these have been admitted to the hospital indicating that we





have a record of 86% of the people who die of cancer in this area.

Per Cent Population — 65 years and over			
The STATE — 5.8%			
Our Hospital Area — 10.%			
Our Towns	Per Cent	Total Population	
*Andover.....	10.9	463	
Ashford.....	9.1	767	
*Canterbury.....	10.0	976	
*Colchester.....	11.2	2200	
Columbia.....	9.6	648	
Coventry.....	12.0	1554	
Chaplin.....	12.6	429	
*Eastford.....	10.8	550	
*Franklin.....	10.0	611	
Hampton.....	11.2	536	
Hebron.....	10.2	879	
Lebanon.....	10.3	1510	
Mansfield.....	6.2	3964	
*Sprague.....	5.9	2539	
Scotland.....	14.7	410	
*Willington.....	7.8	1216	19252
Windham			
Willimantic.....	8.1	13477	13477
*Covered by neighboring Hospital.			

The above chart is a detail study of the percentage of population above 65 in our area, with the total population of the towns.

PART II — GENERAL SURVEY OF THE  
CANCER SITUATION IN THE WINDHAM  
COMMUNITY HOSPITAL FOR THE  
PAST 10 YEARS

E. J. Ottenheimer, M.D.

Before presenting what Walter Lippmann might call a "blizzard of statistics", a few words may be necessary by way of explanation.

To accomplish this survey, every case record with a diagnosis of tumor, benign or malignant,

for the past 10 years, was studied. We discovered in several instances that some malignant tumors had been filed as benign, and vice versa. We found, also, that many cases had been filed as malignant tumors which not only had no pathological diagnosis, nor autopsy, but had not even had X-ray examinations. These were usually patients who came into the hospital in extremis, who died within a few days of admission, and whose general condition precluded any thought of diagnostic procedure. While in most of these cases the history and physical examination strongly suggested the presence of malignancy, we did not feel that the evidence in favor of malignancy was convincing enough to warrant their inclusion in this study.

On the other hand, there were some cases, practically all of them far advanced, that did not have pathological diagnoses, but which were studied carefully, and had thorough radiological examinations which confirmed the diagnosis of malignancy. These cases therefore were included in the study as being clinically, probably malignant.

There were also a certain number of skin cases which did not have pathological diagnoses, but the lesions seemed definitely malignant, were treated as such and were included in the series.

By and large it may be said that the vast majority of cases in this study had pathological diagnoses.

To facilitate analytical comparison, we divided the 10-year period into two five-year periods. Table I shows the number of tumor cases admitted from July, 1928, to June, 1933.

Re-entries, of course, throughout the survey, have been classified as only one case representing

The Windham Community Memorial Hospital, Inc.

Five Year Period — Old Hospital

July 1928 - June 1933

ADMITTED AND TREATED CASES. TUMOR PATIENTS												
Year	1928 - 1929		1929 - 1930		1930 - 1931		1931 - 1932		1932 - 1933		Total	
Sex	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
New Patients	19	54	16	82	14	39	16	44	26	44	91	263
Benign												
Admitted.....	6	36	10	53	9	27	6	31	14	30	45	177
Out Patient.....	3	4	1	2	0	1	0	1	2	2	6	10
Malignant												
Admitted.....	9	12	5	25	4	10	8	12	8	12	34	71
Out Patient.....	1	2	0	2	1	1	2	0	2	0	6	5
Re-entry .....	0	2	1	4	1	1	1	4	0	5	3	16

TABLE 1

the first admission. It will be seen that during the first five-year period there were a total of 51 males and 187 females with benign tumors, and 40 males and 76 females with malignant tumors.

Table 2 represents a similar picture for the second five-year period and here we show a total

of 75 males and 226 females with benign tumors, while there were 80 males and 107 females with malignant tumors, a distinct increase over the first five years.

Table 3 shows the combined figures for the whole ten years — a total of 539 benign tumors, and 303 malignant tumors.

The Windham Community Memorial Hospital, Inc.  
Five Year Record — New Hospital  
July 1933 — June 1938

ADMITTED AND TREATED CASES. TUMOR PATIENTS												
Year	1933 - 1934		1934 - 1935		1935 - 1936		1936 - 1937		1937 - 1938		Total	
Sex	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
New Patients.....	34	58	31	56	28	58	37	102	25	59	155	333
Benign												
Admitted.....	18	36	12	39	15	34	12	70	10	38	67	217
Out Patient.....	1	2	1	2	0	1	4	3	2	1	8	9
Malignant												
Admitted.....	14	20	15	15	8	19	17	22	10	15	64	91
Out Patient.....	1	0	3	0	5	4	4	7	3	5	16	16
Re-entry.....	1	4	1	1	3	10	7	8	1	12	13	35

TABLE 2

Summary  
Ten Year Record

ADMITTED AND TREATED CASES. TUMOR PATIENTS							
	First Five Year Table		Second Five Year Table			Grand Total	
	M.	F.	M.	F.	Male	Female	Total
New Patients.....	91	263	155	333	246	596	842
Benign							
Admitted.....	45	177	67	217	112	394	506
Out Patient.....	6	10	8	9	14	19	33
Malignant							
Admitted.....	34	71	64	91	98	162	260
Out Patient.....	6	5	16	16	22	21	43
Re-entry.....	3	16	13	35	16	51	67
Total — Male - 246		Female - 596					
Total — Benign							
Male.....		126					
Female.....		413					
Malignant							
Male.....		120					
Female.....		183					

842

TABLE 3

We have also prepared a graph\* which shows the steady growth of our tumor cases over the 10-year period. It may be noted here that of all the tumor admissions, 539, or 64%, proved to be benign, and 303, or 36%, malignant.

In Table 4, we present the primary site of all our tumors both benign and malignant.

\*Graph not reproduced but shows a constant preponderance of benign cases as well as a steady increase in tumor cases from 1929 to 1938.

It may be pointed out that there were in our series, 120 breast tumors, of which 54% were benign, and 46% malignant. We may assume that a patient in our community with a lump in the breast has almost a 50% chance of its being malignant. On the other hand, of the 49 tumors of the intestines and rectum, 80% proved to be malignant. Another interesting point shown in this table is that, of the 295 tumors of the female generative organs, 82% were benign,



PRIMARY SITE OF GROWTH  
All Tumors

Organ	Benign	%	Malig.	%	Total	% Total Cases
Buccal Cavity						
Lip — Throat.....	12	46	14	54	26	3%
Skin.....	90	66	47	34	137	16#
Breast.....	65	54	55	46	120	14#
Lung.....	1	10	9	90	10	1
Esophagus.....	0	0	3	100	3	—
Stomach.....	0	0	34	100	34	4
Intestines and Rectum.....	10	20	39	80	49	6%
Pancreas.....	0	0	7	100	7	—
Female Genitalia.....	241	82	54	18	295	35
Male Genitalia.....	57	82	13	18	70	8#
Bladder.....	6	54	5	46	11	1#
Bone.....	2	50	2	50	4	—
Miscell.....	55	72	21	28	76	9%
Total	539	64%	303	36%	842	100%

TABLE 4

and 18% malignant; and of the 70 tumors of the male generative organs, the proportion of benign and malignant tumors was exactly the same.

We may now dispense with any further study of benign tumors, and Table 5 shows the primary site of growth of our 303 malignant cases.

PRIMARY SITE OF GROWTH  
Malignant

Organ	Cases	Per cent of Total Cases
Buccal Cavity	14	4% plus
Skin	47	15% plus
Breast	55	18% plus
Lung	9	3%
Esophagus	3	1% minus
Stomach	34	11% plus
Intestines	18	6% plus
Pancrea	7	2% plus
Rectum	21	7%
Uterus	18	6%
Cervix	19	6% plus
Ovaries — Tubes	17	6%
Bladder	5	1% plus
Prostate	12	4%
Miscel.	24	8%
Total	303	100%

Summary of Cases

Total — Tumor Cases	842
Total — Benign Cases	539
Total — Malignant	303
Benign	64%
Malignant	36%

TABLE 5

It is obvious that our highest incidence was in the breast, representing 18% of all the malignant tumors. One can see that if we grouped the gastro-intestinal malignancies together, and the

malignancies of the female generative organs, these two systems would compare with the high breast incidence.

For the purpose of clarification, we have enumerated in Table 6 the malignancies heretofore grouped as miscellaneous.

DETAIL LIST. MISCELLANEOUS. MALIGNANT  
24 Cases

Melanoma of spleen.....	1
Osteogenic sarcoma of bone.....	1
Sarcoma of hip.....	1
Perithelioma of carotid body.....	1
Carcinoma of thyroid.....	2
Mixed tumor of parotid.....	2
Sarcoma of superior maxilla.....	1
Lymphatic leukemia.....	7
Retroperitoneal sarcoma.....	1
Sarcoma of vagina.....	1
Melanotic sarcoma of groin.....	1
Hodgkins disease.....	3
Carcinoma of common duct.....	1
Carcinoma of testicle.....	1
Total	24

TABLE 6

In the chart shown we have indicated the age incidence in our series of malignancies, the highest incidence occurring in the age group 40-60, with 60-70 not far behind as a group. Only 23 cases in this series occurred below the age of 40.

In making this survey, we felt it would be instructive to know what treatment had been given to all cases in the series as a whole. Table 7 represents an analysis of treatment for all cases in the first five years.

ANALYSIS OF OPERATIVE TREATMENT  
1929 — First Five Year Period — 1933

Treatment	First Year	Second Year	Third Year	Fourth Year	Fifth Year	% Cases	Hospital Deaths
Refused.....	0	0	0	0	0	0	0
Inoperable.....	6	8	6	5	8	31.4	12
Exploration.....	3	1	0	2	2	7.6	7
Palliation.....	9	5	4	7	3	26.6	10
Radical.....	3	16	4	6	7	34.4	1
Deaths.....	11	7	1	6	5	100%	30
Total Cases — 105							

TABLE 7

It is apparent that of all the cancer cases admitted during the past five years, 31.4% were inoperable, 7.6% could be explored only, and 26.6% could be given palliation only. In other words, approximately 66% of cases in this period were hopeless on admission, and in only 34.4% of cases could a cure be attempted.

Table 8 presents a similar picture for the second five-year period. In this period about 53% of all cases were hopeless on admission, and

ANALYSIS OF OPERATIVE TREATMENT  
1934 — Second Five Year Period — 1938

Treatment	First Year	Second Year	Third Year	Fourth Year	Fifth Year	% Cases	Hospital Deaths
Refused.....	0	0	0	0	2	1%	0
Inoperable.....	15	8	5	8	3	25%	17
Exploration.....	1	0	2	4	3	7%	4
Palliation.....	2	6	6	10	7	20%	8
Radical.....	16	16	14	17	10	47%	4
Deaths.....	13	6	2	6	6	100%	33
Total Cases — 155							

TABLE 8

a cure could be attempted in only 47%. This represented, however, a somewhat brighter picture than the first five years.

In Table 9, we have combined the two five-year periods, and, as will be noted, if we exclude the skin malignancies, almost 60% of cases ad-

mitted over the ten-year period were incurable, and in only about 41% could a cure be attempted.

post-operatively to be an operative death. On this basis, we had 5 deaths out of 109 radical procedures, giving an operative mortality of 4½%. We had, however, two other deaths, one 22 and one 45 days post-operatively, which makes a total of 7, or, if you will, a total mortality for radical treatment of somewhat over 6%.

Summary Table  
OPERATIVE TREATMENTS  
1929 — Ten Year Period — 1938

Total — Malignant Cases	303		
Total — Hospital Deaths	63	21%	
Treatment	Cases	Died	Mortality
Refused.....	2	0	—
Inoperable.....	72	29	40%
Explorative.....	18	11	60%
Palliative.....	59	18	30%
Radical.....	109	5	4½%
Total	260	63	

Note: Table excludes malignant skin cases.

TABLE 9

mitted over the ten-year period were incurable, and in only about 41% could a cure be attempted.

It should be stated at this point that in considering operative mortality we followed Mr. Hirsche's plan adopted in his New Haven survey which considered any death within 14 days

Table 10 further analyzes the deaths in the hospital and is self-explanatory.

In Table 11 we have attempted to show the duration of life from hospital admission to death for all cases admitted in the first five-year period. The follow-up was 100%, leaving no untraced cases. It will be seen that, if we exclude the skin malignancies, of the 105 cases admitted during the first five years, only 24% are alive at the end of five years. If we include the skin malignancies, making a total of 116 cases in this period, the total five-year survival was 31%.

We thought it would be interesting to determine how many cases are still alive out of the total ten-year period, and we are depicting this in Table 12.



OPERATIVE TREATMENTS  
1929 — Ten Year Period — 1938  
Summary Table  
HOSPITAL DEATHS. CANCER

29 Deaths — Inoperable cases.....	47% of Total Cancer Death
11 Deaths — Explorative cases.....	17% of Total Cancer Death
16 Deaths — Palliative cases.....	25% of Total Cancer Death
7 Deaths — Radical cases.....	11% of Total Cancer Death
<hr/>	
63 Deaths	Total
Total — Malignant cases.....	303
Total — Hospital Deaths.....	63
Per cent Hospital Deaths.....	21%

TABLE 10

END RESULTS ON TREATED AND UNTREATED CASES  
1929 — Five Year Period — 1933

Time	Duration of Life from Hospital Admission to Death					Total
	Inoperable	Exploration	Palliative	Radical	Refused	
Operative Deaths.....	0	4	7	1	0	12-11%
Under 1 month.....	14	0	2	0	0	16-15%
Under 6 months.....	14	3	8	1	0	26-25%
6 months to 12.....	2	0	4	0	0	6- 6%
1 to 2 years.....	3	1	2	3	0	9- 8%
2 to 3 years.....	0	0	1	5	0	6- 6%
3 to 4 years.....	0	0	0	4	0	4- 4%
4 to 5 years.....	0	0	0	1	0	1- 1%
Lived over 5 years.....	0	0	3	22	0	25-24%
Untraced.....	0	0	0	0	0	
						Total 105
Total admitted cases — 105						
Survival 24%						
Untraced none						

(Skin cases excluded)

TABLE 11

SUMMARY — TEN YEAR TABLE — MALIGNANT

Site	Cases	Hospital							Survival
		Deaths	6 mo.	1 yr.	2	3	4	5	
Buccal Cavity.....	14	2	5	2	3	2	—	—	0
Skin.....	47	0	0	2	1	—	—	—	43
Breast.....	55	8	2	4	3	8	5	—	25
Lung. Bronc.....	9	3	4	—	1	—	—	—	1
Esophagus.....	3	1	1	1	—	—	—	—	0
Stomach.....	34	13	13	3	1	1	—	—	3
Intestines.....	18	8	4	3	—	—	—	—	3
Pancreas.....	7	3	3	—	1	—	—	—	0
Rectum.....	21	6	6	2	1	1	1	—	4
Uterus.....	18	6	—	—	—	1	—	—	11
Cervix.....	19	2	2	1	2	1	1	2	8
Ovaries Tubes.....	17	3	4	2	1	1	—	—	6
Bladder.....	5	—	—	2	—	—	—	—	3
Prostate.....	12	2	2	1	3	—	—	—	4
Miscel.....	24	6	4	2	4	1	—	—	7
Total	303	63	50	25	21	16	7	3	118
Survival.....		39%							
Hospital Deaths.....		21%							
Five Year Deaths.....		40%							

TABLE 12

This is obviously not a follow-up, since it is impossible to determine a five-year follow-up on cases admitted within the last five years. However, if viewed in the proper light, the table does show that of the 303 malignant cases, 118, or 39%, are living at the present time. There were no untraced cases in the entire series. The table shows also the survivals according to the

primary site of growth.

Heretofore we have been looking at this series as a whole. We felt that this survey would not be complete without some attempt to break down in systems, at least, some of these statistics. Accordingly we present in Table 13 the picture of our gastro-intestinal malignancies during the ten-year period.

END RESULTS IN THE TREATMENT OF CANCER OF THE DIGESTIVE APPARATUS

1929 — Ten Year Period — 1938

Total Cases — 76

Site	Total	Treatment		Deaths in Hospital		Died Outside		Survival
		Radical	Other	Radical	Other	6 mo.	5 yr.	
Esophagus.....	3	0	3	0	1	1	1	0
Stomach.....	34	2	32	0	13	13	5	3
Intestine.....	18	6	12	3	5	5	2	3
Rectum.....	21	6	15	2	4	6	5	4
—1 Died 7th year								
Total .....	76	14	62	5	23	25	13	10
Per %	100%	18%	82%	8%	35%	57%		13%

of total Deaths

Total Cases.....	76
Total Deaths, Hospital.....	28—37%
Total Deaths, Outside.....	38—50%
Survival.....	10—13%

(Unclassified None)

TABLE 13

There was a total of 76 cases, of which 34 were in the stomach, 18 in the intestines, and 21 in the rectum. Of the total, only 18% could have radical surgery and 82% were inoperable on admission. Of all the gastro-intestinal malignancies for the ten-year period only 13% are alive today. The five-year end result, however, as shown by a follow-up of all cases admitted during the first five years — no untraced cases — was only 10%

A similar analysis was made of all the malignancies of the female generative organs, and is shown below in table 14.

There was a total of 55 cases in which radical treatment was attempted in 30 cases and palliative in 25. Of all the cases in this ten-year period, 46% are alive today.

A study of the five-year end results on all cases admitted during the first five-year period shows that 44% were alive at the end of five years.

By way of conclusion we would like to say that this survey has been invaluable to us in many ways. In going over our records we found many defects and it has inspired us to correct these delinquencies in the future. It has stimulated us to be more energetic in securing autopsies on suspiciously malignant cases. It has given us a more intelligent, more comprehensive, albeit depressing, picture of cancer in the area which we serve; and lastly and most important, it has stiffened our resolve to improve the appalling status of cancer in our community.



END RESULTS IN THE TREATMENT OF CANCER OF THE FEMALE GENITALIA  
1929 — Ten Year Period — 1938  
Total Cases — 55

Site	Total	Radical	Treatment		Deaths in Hospital	Died Outside		Survival
			Radical	Other		6 mo.	5 year	
Uterus.....	18	11	7	2	4	0	1	11—1 died end 9 year
Cervix.....	19	9	10	0	2	1	8	8
Ovaries.....	17	9	8	0	3	4	4	6
Vagina.....	1	1	0	0	0	0	1	0
Total	55	30	25	2	9	5	14	25
Per cent	100%	54%	46%	7%	30%		63%	46%
of Total Deaths								
Total cases.....						55		
Total Deaths Hospital.....						11—20%		
Total Deaths Outside.....						19—34%		
Survival.....						25—46%		
Untraced cases.....						0		

TABLE 14

PART III — CARCINOMA OF THE BREAST  
Richard Shea, M.D.

We have made a special study of the breast cases of carcinoma over a ten year period, from 1929 to 1938. This survey is not large and we do not attempt to prove anything from these figures, but it gives an accurate picture of carcinoma of the breast in our community.

In our series of 62 cases of breast carcinoma the age incidence was greatest in the years from 40 to 60 with over 50% of the cases occurring at this time. Twenty-two per cent of the cases occurred between 60 and 70, and 9.6% from 70 to 80, and 11.3% between the ages of 25 and 40. There were no cases under 25 years of age and a few cases over 80.

On admission to the hospital 10 cases or 16.1% were inoperable. Since these cases represent the terminal stages of carcinoma of the breast, a large per cent — 70% — died in the hospital. Eight cases or 12.9% received palliative treatment and of these cases 25% died in the hospital. The remaining 44 cases, or 71% had radical treatment, which consists of radical amputation of the breast with axillary glands and also post-operative radiation and sterilization if they are in the child bearing age. None of these cases died in the hospital. Our operative mortality is nil.

Grouped according to the extent of disease we find 20.9% of our cases with the cancer confined to the breast, 33.8% with axillary metastases, 24.4% with remote metastases. In the remain-

ing group of 20.9% there was no pathological report on the axillary glands and it is unknown whether or not axillary metastases were present.

A charting of the five year survival rate of all 62 cases of carcinoma of the breast shows a three year and five year survival rate of 35%. At the end of 6 months there was an 85% survival, at the end of 1 year 75%, and at the end of two years 55%. This group includes all cases of breast carcinoma, inoperable as well as operable.

PART IV — ANALYSIS OF THE DELAY IN  
CANCER IN THIS AREA  
Brae Rafferty, M.D.

In this part of the study we have attempted to find out how long the patient delayed in going to his physician and how long the physician delayed in beginning treatment. We have chosen 100 consecutive cases listed on our tumor clinic records. An even 100 cases are used for statistical use.

In order to get some picture of how our rural figures stand up with other communities, we have compared our statistics with the published figures from the survey of the New Haven hospitals from 1925 to 1934. This is taken as a representative urban, teaching community. Much to our surprise we find that bad as our figures are, they are no worse than those of the New Haven hospitals. The New Haven average delay was 15.4 months while ours for a ten year period was 13.9, or for our 100 consecutive clinic cases, 12.3 months.

THE TIME INTERVAL OF TUMOR CASES  
A Study of 100 Consecutive Clinic Cases

Male 37		Female 63		Interval in Months—		Ward 16	Private 84
Organ	No.	First Symptom to Doctor	Interval in Months Doctor to Hospital	Interval in Months Doctor to Hospital	First Symptom to Hospital		
Tongue . . . . .	1	2.		.25	2.2		
Buccal . . . . .	8	15.7		16.5	32.2		
Esophagus . . . . .	1	1.2		3.5	4.7		
Stomach . . . . .	9	6.4		1.1	7.5		
Intestine . . . . .	7	2.1		3.2	5.3		
Rectum . . . . .	9	4.2		7.5	11.7		
Uterus . . . . .	16	4.5		4.	8.5		
Ovaries . . . . .	5	6.2		6.2	12.4		
Skin . . . . .	6	27.		9.6	36.6		
Breast . . . . .	22	9.7		4.0	13.7		
Bladder . . . . .	2	4.6		12.0	16.6		
Prostate . . . . .	4	10.1		14.7	24.8		
Miscel.							
Lung . . . . .	5	5.6		.5	6.1		
Sarcoma . . . . .	2	1.5		7.8	9.3		
Leukemia . . . . .	2	.3		.6	.9		
Hodgkins . . . . .	1	2.1		1.0	3.1		
Total	100	6.46		5.8	12.3		

Time Interval — Both Hospital Admitted and Clinic Cases  
Ten year period 1928 - 1938. Total 270 cases  
Total Average — 13.9 months  
TABLE 1

Having determined the length of the delay, we now show the reasons for it. We have listed the causes for delay as suggested on the tumor clinic sheet as made up by the Record Committee of the Association of Connecticut Tumor Clinics. We then compared these results with those from the Massachusetts State Tumor Clinics as reported by Lombard. Negligence on the part of the patient was the cause for the delay in 45% of our cases, as compared to 42.1% in Lombard's series. Ignorance on the part of the patient added another 4% in our series. It is, perhaps, rather remarkable that only 2% gave an economic reason for delay and this figure coincides closely with Lombard's 2.5%. This point may be important in view of the present movement towards State or Federal subsidy, which is allegedly based on economic need. Fear was the cause for delay in 9% as compared with Lombard's 3.2%. "Other reasons," amounting to 18% include the group in which extreme age, or a debilitating systemic disease were factors, or the cases in which there was no delay or a reasonably short one. It might be termed the legitimate delay group. Lombard has chosen the arbitrary figure of 2 months as constituting no delay, and lists his largest number, 44.7% in this

group, which in our series was 18%. The Massachusetts Study for some reason did not list poor medical advice as a cause for delay. Our figure is 22% due to this cause. We feel that 22% is a pretty bad figure and it takes some courage to admit it. But we believe that it is the most important figure, at least in this part of the study. Perhaps the policy chosen in recording the poor medical advice is too severe or hypercritical but the policy was arrived at, not by considering extenuating circumstances of a particular case or the difficulties encountered by the practitioner, but from the patient's point of view in retrospect, now that the ten year period is over. It has the point of view of keeping in mind the end results for the period, rather than accusing the physician of missing the diagnosis, because of lack of thoroughness, or of not being aggressive enough in his advice for earlier treatment. For no matter wherein the fault lies, unless there is a radical change in the treatment of cancer, comparable say to the changes that occurred in surgery with the advent of asepsis, the only obvious improvement that can be made must be in the factor of delay. The treatment of cancer is pretty well standardized, for there has been



relatively little change in the past 10 years in either the surgical or radiological technique. (This opinion is not generally accepted.—Ed.) Apparently then, the main point to stress is the strong need for diminishing the delay period. For the patient a continuance or intensifying of an educational program seems to be indicated.

As far as the physician is concerned, we do not believe that it is a matter of accusing the doctor of not being well enough trained nor of lack of reasonable use of the diagnostic aids at hand, but rather of being made more conscious of the “delay in cancer” by showing him the actual results of his work at the end of a ten year period.

PART V — ANALYSIS OF THE ECONOMIC PHASE OF THE CANCER SITUATION IN OUR AREA

Mr. W. B. Sweeney, Superintendent

RESIDENCY TABLE

1929 — Admitted Cases — 1933

Year	Resident	Non-Res.	Community	Total
			Towns	
First.....	12	2	7	21
Second.....	12	7	11	30
Third.....	6	1	7	14
Fourth.....	10	4	6	20
Fifth.....	10	4	6	20
Total	50	18	37	105

1933 — Admitted Cases — 1938

Year	Resident	Non-Res.	Community	Total
			Towns	
First.....	19	4	11	34
Second.....	10	6	14	30
Third.....	11	8	8	27
Fourth.....	22	3	14	39
Fifth.....	17	3	5	25
Total	79	24	52	155

Summary

Ten Year Period — Admitted Cases

Resident.....	129
Non-Res.....	42
Comm. Towns.....	89

Total 260

TABLE 1

Five Year Period — 1933 - 1938  
ECONOMIC PHASES OF 155 ADMITTED CANCER CASES

Location	Cases	% Total	Days Care	Cash Paid	Average per day	Average stay	Average Amt. Patient paid
Private Room.....	45	30%	1341	\$11576.58	\$8.63	30 days	\$257.25
Private Ward.....	89	56%	2380	\$11185.68	\$4.70	28 days	\$130.06
Public Ward.....	6	4%	94	\$364.80	\$3.87	16 days	\$ 60.80
Town and State Indigents.....	15	10%	596	\$ 1290.22	\$2.16	39 days	\$ 86.00

Above tables include all radiology fees

Hospital Rates

Private Rooms	\$6.00, \$7.00, \$8.00 per day
Private Ward	\$3.50 per day
Public Ward	\$2.50 per day
Town Rate	\$2.50 per day
State Rate	\$1.14 per day

The Windham Community Memorial Hospital, Inc.

Willimantic, Conn.

TABLE 2

1933 — Five Year Period — 1938  
ECONOMIC PHASES OF 155 ADMITTED CANCER CASES

Summary

Period 5 years. Total cases 155

Average stay all cases . . . . .	28 days
Average Cost to Patient . . . . .	\$157.53
Average Patient day Hospital cost . . . . .	\$ 5.36
Average Cancer Patient Hospital cost . . . . .	\$160.08
30% of Cancer cases Paid full cost of Care	
56% of Cancer cases Paid 60% cost of Care	
14% of Cancer cases Public Charges	

Occupancy Figure

67 of the total cases — occupancy less than 5 days  
36 of the total cases — occupancy over 30 days  
Longest occupancy 186 days Private Ward — charges \$ 693.00  
Highest billing 153 days Private Room— charges \$1006.00  
Payments on Private Room Cancer cases for five years was 100%

TABLE 3

\$257.25, private ward average per case \$130.06, public ward average per case \$60.80, town and state indigent average per case \$86.00. These figures include radiology, medical and anesthesia fees, but not surgeons' fees.

Here we attempted to summarize briefly the above statistics. The average hospital stay was 28 days, the average cost to patient per day was \$5.36.

Compare these figures with the general average of all cases in the same period which was 11.2 days stay and \$4.90 per day cost. The average amount paid by all cancer cases for the five year period was \$157.53 while the actual net cost to the hospital was \$160.08. The proportion of cancer cases able to pay full cost of care and also the group able to pay private ward or 60% cost of their care is far in excess of the figures for all average cases. The results of the cost study are in line with Dr. Rafferty's interval tables that show a small percentage giving economic reasons for cause of delay. The 14% figure in cancer cases as public charges is lower than the average figure for all types of public charge cases in the same period, which was 18%. 30% of cancer cases paid full cost of care, 56% paid 60% cost of care and 14% were public charges. 67 of the total cases had occupancy of less than 5 days and 36 of over 30 days. Payments on private room cancer cases for five years was 100%.

Table 4 shows a comparison of the average stay of the cancer cases for the first five year period and the second five year period, also a comparison is made with the average stay for all other cases, which is 11.2 days.

Windham County Memorial Hospital  
1928 - 1938 CANCER CASES  
Average Hospital Stay

1929 - 1933		1934 - 1938	
Yr.	days stay	Yr.	days stay
1929	32	1934	18
1930	25	1935	18
1931	26	1936	22
1932	23	1937	27
1933	28	1938	39
Average stay cancer case		— 28 days	
Average stay non-cancer case		— 11.2 days	

TABLE 4

I secured the figures in Table 5 so that the professional men on my staff would not become too optimistic. This table shows the median incomes of New England families (Connecticut Section). For all families in cities, \$1,344, in villages, \$1,232, on farms \$1,142. For non-relief families: city, \$1,447, villages \$1,447, farm \$1,180. The average number of persons per family was: 3.6 in cities, 3.9 in villages, 4.2 on farms. 96% of families in cities had earners and 95% in villages. 35% of city families were property owners and 62% renters. 52% of families in villages were property owners and 47% renters. 86% of farm families were property owners and 13% renters.

Table 6 belongs to Dr. Kinney's study and shows a study of the deaths from cancer from 1928 to 1938. Nine per cent of city deaths and 11% of rural communities were from cancer. There is an average of 17 cancer deaths per year in urban communities and 25 in rural localities. There is an average of 6.3 deaths from cancer in the hospital per year.

ECONOMIC PHASE  
Findings from New England Families  
(Vocational Assoc., Connecticut Section. 1938)

Median Income	City	Village	Farm
All Families.....	\$1344.	\$1232.	\$1142.
Non-Relief Families.....	\$1447.	\$1447.	\$1180.
Average Number Persons per Family			
All.....	3.6	3.9	4.2
Non-Relief.....	3.6	3.8	4.2
Relief.....	4.3	4.6	4.7
Per cent of Families having any Earner.....	96.4	95.8	—
Per cent having two or more Earners.....	22.5	18.4	—
Per cent Property Owners.....	35.5	52.5	86.
Per cent Renters.....	62.5	47.5	13.

TABLE 5

TOTAL DEATHS AND DEATHS FROM CANCER  
In Willimantic and the 17 Community Towns  
1928 to 1938

Urban	Deaths Cancer	Other Causes	Cancer Deaths Per cent of Total 9% plus
City.....	173	1647	
Rural Towns.....	258	2123	11%
Average Deaths per year — Cancer, Urban.....	17.3 cases		
Average Deaths per year — Other Causes, Urban.....	164.7 cases		
Average Deaths per year — Cancer, Rural.....	25.8 cases		
Average Deaths per year — Other Causes, Rural.....	212.3 cases		
Estimated Cancer Deaths, all per year.....	21.5 cases		
Hospital Cancer Deaths, average per year.....	6.3 cases		
Hospital Cancer Deaths including follow up for the 10 year period, per year.....	18.5 cases		

TABLE 6

PART VI — GENERAL SUMMARY  
E. J. Ottenheimer, M.D.

The Windham Community Memorial Hospital  
SUMMARY

1. **100% Follow-up** on our 303 Malignant cases.
2. The percentage of our population over 65 years of age for the area (10%) is almost **twice the State figure (5.8%)**.
3. 68% of our Admitted cases (exclusive of skin) could have either **Palliative or NO treatment**.
4. Operative mortality for **radical treatment** was **4 1/2%**.
5. Five Year Survival for all cases **31%**.
6. Time Interval — First Symptom to Admission **12.3 months**.
7. **Only 2%** gave Economics as reason for delay.
8. **Only 14%** of Cancer cases required Tax Funds.
9. The average Hospital stay — 28 days. The average cost to the Patient — **\$157.53**.

DISCUSSION

Mr. Herbert Hirsche, State Department of Health, Hartford, compared the results of treatment at the Windham Community Memorial Hospital with those obtained from an analysis of 1474 unselected cases from the general hospitals in New Haven during the five year period 1925 to 1929. His first slide showed the five year survival curve of 508 cancers of the digestive system. At the end of five years 5.3% remained alive as compared to the 10% in Willimantic. It was felt that the difference in figures might be explained on the smaller number of cases in the Willimantic series and the larger proportion of stomach cases in the New Haven series. The second slide based on 49 cancers of the respiratory system showed 6.1% surviving five years. A third slide based on 76 cancers of the male genital system showed 14.5% surviving the fifth year. The fourth slide of 228 cancers of the female genital system gave a 23.7% five year survival.

The fifth slide showed results obtained at the University of California Hospital in cervix carcinoma. After five years 89.5% of the stage 1 cases, 40.6% of the stage 2 cases, 13% of the stage 3 cases were alive. In the stage 4 cases the average length of life was 18 months. The five year survival of all cases was 20.3% which very closely approximated the 20.7% found in the New Haven Hospitals. The sixth and seventh slides showed a 34.3% survival in breast carcinoma in the New Haven series as compared to a 32% five year survival in the California series. The Windham Hospital figure of 35% checked quite closely. It was also noted that 62% of the breast carcinoma in the



New Haven series had extended beyond the breast at the time of admission.

The final slide showed that of the total 1474 cancer cases in the New Haven series 19.8% survived for 5 years. Dr. W. F. Wild in his analysis of cases in Bridgeport found a 20% survival. The Windham Hospital figure of 24% included skin carcinomas. It was accordingly felt that the probable percentage of "cures" in our general hospitals is around 20% at the end of the fifth year.

**Dr. Philip G. McLellan, Hartford,** presented three slides of comparative data from an analysis of Hartford Hospital Tumor Clinic experience. The first slide based on a total of 2015 admissions for the five year period 1932 to 1936 showed the following anatomical distribution:—

Gastrointestinal Tract.....	29%
Stomach.....	9.3%
Colon.....	8.8%
Rectum.....	3.6%
Gynecological.....	18. %
Cervix.....	9.8%
Breast.....	14.9%
Genito-urinary (s female genit).....	10.1%
Prostate.....	4.4%
Skin, and melanoma.....	6.7%
Mouth, nasopharynx, etc.....	6.0%
Leukemias, Hodgkins disease.....	4.9%
Respiratory tract.....	4.4%
Miscellaneous.....	6.0%

The second slide showed that from an analysis of 171 cervix carcinomas 63% fell into stages 1 and 2 and that there was a distinct trend to be noted in getting this type of case to the hospital earlier. The third slide was based on the study of 370 consecutive admissions of breast carcinomas from 1934 to 1938 and compared the stage of advancement of cases coming from Hartford and the immediate environs with those coming from more distant points. Patients coming from greater Hartford were 42% stage 1, 20% stage 2, 27% stage 3, 11% stage 4, as compared to 33% stage 1, 16% stage 2, 34% stage 3, 17% stage 4, from more distant communities. This meant that 62% of the cases from greater Hartford were relatively favorable for treatment as compared to 49% of the cases admitted from more distant points.

**Dr. Charles L. Larkin, Waterbury,** complimented the staff of the hospital for their excellent program and asked for discussion by delegates from the other tumor clinics of the association.

**Dr. William A. Goodrich, Waterbury,** reported on a series of 53 cases of breast carcinoma for a 5 year period ending with 1935. Fifty of these cases were operated upon, 70% were alive at the end of the first year, 60% the second, and 57% at the end of the third year. His conclusions were that the patients were not seen early enough. In 18 patients with subjective symptoms for less than 3 months, 12 cases already had axillary metastases. Routine preoperative X-ray studies had not been used nor did many of the patients receive pre- or post-op irradiation therapy.

**Dr. A. W. Oughterson, New Haven,** reported that he had been particularly interested in cancer of the stomach which comprises nearly one third of all cancer occurring in man. From a study of the results in the New Haven Hospital Clinic and also in the City of New Haven he had

found that the radical resection of the tumor could be performed in only 8% of the patients, the operative mortality had been about 50%, leaving about 4% who ever had a chance for cure. Of this 4% less than one fourth did not have metastases in the lymph nodes which could not be removed so that the present effectiveness of treatment in the cure of cancer of the stomach is less than 1%. It was pointed out that late diagnosis is the chief factor responsible for these discouraging results. Sixty per cent of these patients had had symptoms for 6 months or more before entering a hospital and 40% had had symptoms for more than a year. Although it was easy to state that in 50% of these cases the diagnosis should have been made earlier it was quite another matter to point out exactly how this could be accomplished as there is no symptom complex characteristic of cancer of the stomach.

In cancer of the colon he had found results more encouraging. Fifty per cent had had symptoms for 6 months or more. Forty per cent, however, were suitable for radical removal and nearly 60% of these patients were alive at the end of five years. Thus the effectiveness of curing cancer of the colon in New Haven was about 16% as contrasted to less than 1% in cancer of the stomach.

**Dr. James R. Miller, Hartford,** expressed interest in Mr. Sweeney's report on the economic aspects of the cancer problem and brought out the fact that the legislature began its session in January, and that it was probable that many kinds of schemes concerning medical care, including cancer, would be introduced. Willimantic was in an area in which one would expect a great need for tax support. These figures gave the lie to this belief and it was suggested that we should try to get some of this information across to the legislators. As far as delay was concerned, Memorial Hospital of New York takes three months as an allowance for the first visit to the doctor and six weeks between the first visit and treatment.

**Dr. R. R. Agnew, Norwich,** expressed concern over the delay due to the physician in getting the patient treated early and wished that something might be done to increase the attendance at these Association meetings.

**Dr. Charles L. Larkin, Waterbury,** asked how many physicians from Willimantic and the surrounding towns were present. Nine out of 17 on the hospital staff and of the 24 in the surrounding country, or approximately one-third of the doctors in this territory, were found to be present. He stressed that it was a real problem to get the doctors who need information about cancer to attend these meetings. All the doctors in the community had been invited. In Waterbury about 10% of the local physicians attended the meetings despite every possible inducement to attend, even to including a free dinner and all that went with it.

**Dr. Carl C. Harvey, Middletown,** complimented the staff on the completeness of their survey. In his experience he had always felt that the economic cause for delay had been small and that people in the low economic brackets had been getting pretty adequate medical care as far as finance was concerned. This impression corresponded well with the 2% delay due to economics as found in this survey. The high percentage of delay attributed to the physician he felt was in part unfair, as it was impossible to send every patient complaining of indigestion for a complete gastrointestinal study. He expressed the opinion that work should be continued in the educational field.

# An Analysis of Data Pertaining to Cases of Syphilis and Gonorrhea Reported in Connecticut During 1938

BY A SUB-COMMITTEE ON VENEREAL DISEASE CONTROL OF THE  
CONNECTICUT STATE MEDICAL SOCIETY

The Connecticut County Medical Societies have appointed Venereal Disease Control Committees which function as Sub-Committees of the Public Health Committee of the State Medical Society. This is the second report of a sub-committee on Venereal Disease Control regarding data on syphilis and gonorrhea in Connecticut. Similar data were compiled for the year 1936 and subsequently reported in the Journal. These data contained in this report are very similar to that contained in the previous report. However, it should be pointed out that the data herein presented contains all the cases of syphilis and gonorrhea reported in the state. The previous report did not contain the cases of syphilis reported from various state institutions. The figures contained in the following tables should be of interest particularly to health officers and also to physicians throughout the state.

In Table No. 1 will be noted the report rate of cases of syphilis and gonorrhea per 100,000 population in the eight counties of the state for the year 1938. The case rate for 1936 was 132.04 and for the year 1938 was 135.49. The case rate for gonorrhea during 1936 was 85.23 and for the year 1938 was 73.22 for the eight counties of the state. The total number of cases of gonorrhea reported in 1938 was 1,310 compared with 1,506

for 1936. During 1936 there were 2,333 cases of syphilis tabulated, but this number did not include the institutional cases. Whereas during the year 1938 the 2,424 cases of syphilis reported does include all institutional cases reported from such institutions as the state mental hospitals, tuberculosis hospitals, etc.

In Table No. 2 the cases and case rates of syphilis and gonorrhea are tabulated by population. The syphilis case rate will be noted to be smaller in the towns under 5,000 population. For the year 1936 the low case rates for both syphilis and gonorrhea occurred in this group. However, during 1938 the low case rate for gonorrhea occurred in the 10,000-25,000 population group. The highest case rates for both syphilis and gonorrhea occurred in the population group of over 50,000. This occurred in both the years under consideration.

TABLE 2  
REPORT RATES BY POPULATION GROUPS  
PER 100,000

Towns	Population	Syphilis		Gonorrhea	
		Cases	Rate	Cases	Rate
Under 5,000	198,130	99	49.97	75	37.85
5,000-10,000	164,821	124	75.23	59	35.80
10,000-25,000	266,424	156	58.55	65	24.40
25,000-50,000	407,499	465	114.11	219	53.74
Over 50,000	752,148	1,580	210.07	892	118.59
Total	1,789,022	2,424	135.49	1,310	73.22

TABLE 1  
REPORT RATES BY COUNTIES — PER 100,000

County	Population	Syphilis		Gonorrhea	
		Cases	Rate	Cases	Rate
Hartford	490,243	794	161.96	515	105.05
New London	130,516	151	115.69	55	42.14
New Haven	502,423	707	140.72	329	65.48
Fairfield	439,846	616	140.05	285	64.80
Middlesex	54,473	42	77.10	32	58.74
Windham	54,086	49	90.60	27	49.92
Litchfield	87,621	41	46.79	57	65.05
Tolland	29,814	24	80.50	10	33.54
Total	1,789,022	2,424	135.49	1,310	73.22

In view of the higher case rates in the larger cities, that is over 50,000 population, the cases and case rates of both syphilis and gonorrhea are listed in Table No. 3.

For 1938 the case rate for syphilis for Hartford was 297.71 compared to a syphilis case rate of 340.12 during 1936. Another interesting fact is that during 1936 the case rate for syphilis in New Britain was 95.89 but during 1938 the case rate was 133.12. The case rate in Stamford also increased slightly for syphilis cases. The case rate



for gonorrhea decreased in most every city under this group except New Britain, the rate being 103.83 for 1938 and 74.58 for 1936.

TABLE 3  
REPORT RATES TOWNS OVER 50,000 POPULATION — PER 100,000

Towns	Population	Syphilis		Gonorrhea	
		Cases	Rate	Cases	Rate
Hartford	185,417	552	297.71	355	191.46
New Haven	165,484	429	259.24	212	128.11
Stamford	70,204	122	173.78	62	88.31
Waterbury	106,500	111	104.23	60	56.34
New Britain	75,123	100	133.12	78	103.83
Bridgeport	149,420	266	178.02	125	83.66
Total	752,148	1,580	210.07	892	118.59

In Table No. 4 will be noted a comparison of the case rates of both syphilis and gonorrhea for towns between 25,000 and 50,000 population. The report rate for syphilis ranges from 52.71 to 263.08 for the year 1938. However, for the year 1936 the case rates for syphilis range from 3.63 to 390.29. These figures indicated an improvement in reporting of cases of syphilis in a great many of the towns of this group. The total case rate for syphilis, however, was only slightly higher for 1938 than for 1936. The total case rate for gonorrhea for the towns in this group was slightly lower for 1938 than for 1936. These rates being 53.74 and 63.76, respectively. There also appeared a more consistent reporting rate for gonorrhea among these various towns for 1938 than for 1936.

TABLE 4  
REPORT RATES TOWNS 25,000-50,000 POPULATION — PER 100,000

Towns	Population	Syphilis		Gonorrhea	
		Cases	Rate	Cases	Rate
New London	32,926	86	261.19	21	63.78
Middletown	26,118	30	114.86	26	99.55
Norwalk	42,524	114	268.08	20	47.03
Greenwich	41,830	52	124.31	34	81.28
Danbury	30,784	20	64.97	24	77.96
Norwich	34,425	22	63.91	17	49.38
West Haven	26,552	35	131.82	13	48.96
Bristol	34,846	21	60.27	15	43.05
Meriden	42,500	32	75.29	11	25.88
Torrington	28,261	17	60.15	27	95.54
West Hartford	37,941	20	52.71	5	13.18
Hamden	28,792	16	55.57	6	20.84
Total	407,499	465	114.11	219	53.74

In Table No. 5 will be noted the report rates for towns between 10,000 and 25,000 popula-

tion. Also in this population group there is a wide variety in the number of cases reported both in regard to syphilis and gonorrhea. The reports range for syphilis from zero to 149.91. One town in this group of a population of 24,731 did not report a single case of syphilis. The report rate for gonorrhea ranges from zero to 74.20. It is believed that these figures do not represent the true incidence of these diseases, but reflects more upon the efficiency of reporting of cases.

TABLE 5  
REPORT RATES TOWNS 10,000-25,000 POPULATION — PER 100,000

Towns	Population	Syphilis		Gonorrhea	
		Cases	Rate	Cases	Rate
Derby	11,288	1	8.86	2	17.72
Groton	12,007	18	149.91	7	58.30
Ansonia	22,113	8	36.18	2	9.04
Windham	13,477	18	133.56	10	74.20
East Haven	11,372	17	149.49	2	17.59
Windsor	10,436	8	76.66	2	19.16
Manchester	24,877	9	36.18	6	24.12
East Hartford	21,530	24	111.47	7	32.51
Shelton	10,624	6	56.48	7	65.89
Milford	14,885	20	134.36	9	60.46
Stonington	11,660	5	42.88	1	8.58
Enfield	14,757	3	20.33	5	33.88
Fairfield	21,838	5	22.90	1	4.58
Stratford	24,731	0	.....	1	4.04
Naugatuck	14,415	6	41.62	1	6.94
Wallingford	16,353	2	12.23	0	.....
Wethersfield	10,061	6	59.64	2	19.88
Total	266,424	156	58.55	65	24.40

Cases of syphilis reported by stage of disease are tabulated by county in Table No. 6. During 1938 there were 87 cases of primary syphilis and 243 cases of secondary syphilis reported compared to 111 cases of primary and 219 cases of secondary syphilis for the year 1936. There were 989 cases of tertiary syphilis reported in 1936 compared with 1,010 in 1938. For 1936, 185 cases of congenital syphilis were reported and for the year under consideration there were 161 cases reported. These figures are notably encouraging as these cases of congenital syphilis are on the decrease however small. The stage of the disease was not noted on 877 reports for 1938.

Table No. 7 gives the percentage of primary and secondary cases for the various counties as well as the total infectious cases which were reported during 1938.

The cases of gonorrhea reported by stage of disease will be noted in Table No. 7A. Of the



TABLE 6  
CASES OF SYPHILIS REPORTED BY STAGE  
OF DISEASE

County	P.	S.	T.	C.	C.N.S.	N.S.	Total
Hartford	24	154	340	39	7	230	794
New London	7	5	44	7	3	85	151
New Haven	24	49	354	52	29	199	707
Fairfield	14	21	195	52	4	330	616
Middlesex	4	3	23	4	..	8	42
Windham	9	5	22	3	..	10	49
Litchfield	4	4	24	1	3	5	41
Tolland	1	2	8	3	..	10	24
Total	87	243	1,010	161	46	877	2,424

TABLE 7  
REPORTED CASES OF INFECTIOUS SYPHILIS  
PER CENT OF TOTAL

County	Primary		Secondary		Total Infectious	
	Cases	Per cent	Cases	Per cent	Cases	Per cent
Hartford	24	3.02	154	19.40	178	22.42
New London	7	4.64	5	3.31	12	7.95
New Haven	24	3.40	49	6.93	73	10.33
Fairfield	14	2.27	21	3.41	35	5.68
Middlesex	4	9.53	3	7.14	7	16.67
Windham	9	18.37	5	10.20	14	28.57
Litchfield	4	9.77	4	9.76	8	19.51
Tolland	1	4.17	2	8.33	3	12.50
Total	87	3.59	243	10.02	330	13.61

total of 1,310 cases of gonorrhea reported in the state during 1938 there were 915 of these cases which were acute. There was a total of 5 cases of ophthalmia neonatorum and 12 cases of gonorrheal vaginitis. There were 96 cases of chronic gonorrhea reported. The gonorrheal ophthalmia cases numbered 7, some of these infections were in adults but most of them were in children over fourteen days of age.

TABLE 7A  
CASES OF GONORRHEA REPORTED BY STAGE  
OF DISEASE

County	Acute	O.N.	G.V.	C.	Eye	N.S.	Total
Hartford	399	1	..	32	2	81	515
New London	38	.	..	8	.	9	55
New Haven	266	2	9	24	2	26	329
Fairfield	121	1	3	17	1	142	285
Middlesex	23	.	..	7	.	2	32
Windham	15	.	..	3	1	8	27
Litchfield	45	1	..	4	1	6	57
Tolland	8	.	..	1	.	1	10
Total	915	5	12	96	7	275	1,310

The data listed in the foregoing tables should be a reminder to all physicians and health officers that syphilis and gonorrhea are major public health problems. The practicing physician should be aware of the fact that he is not only responsible for reporting cases diagnosed by serial number as is required by law, but also to report all cases lapsing treatment by name, address, sex, occupation, etc., to the local health officer. The local health officer should also realize that he has a definite responsibility in co-operating with the local physicians in seeing to it that all cases of lapsing treatment are followed up and referred back to the physician so that treatment may be continued as is necessary.

This analysis of the cases of syphilis and gonorrhea reported should be instructive for the following reasons:

1. It shows that use is made of the reports of cases of both syphilis and gonorrhea and that the reports are not simply filed away and forgotten.

2. The results of the analysis are a rough indication of how much work regarding the control of syphilis and gonorrhea is being carried on in that particular city or town.

3. Such studies made from year to year will serve as an index to the progress or lack of progress in the control of syphilis and gonorrhea.



### ONLY FIFTEEN MINUTES REQUIRED IN NEW SYPHILIS TEST METHOD

A new test, requiring only fifteen minutes, for the demonstration of the syphilitic organism is reported by Leon Friedman, M.D., Philadelphia, in *The Journal of the American Medical Association* for Jan. 14.

The test is especially applicable in cases of gonorrhea in which syphilis is suspected and, in comparison with other tests, saves considerable time.

The principle of the test is centrifugation of the gonorrheal discharge, or any other body fluid capable of being collected in a capillary tube, at low speed. This gives a clear specimen of serum suitable for dark field examination.

The author isolated the syphilitic organism from the gonorrheal discharge of one patient fifty days before the blood test showed the organism and in two patients whose history was not suggestive of syphilis.

## A Full Time Secretary

At its Annual Meeting in May 1936 the House of Delegates of the Connecticut State Medical Society took a step which will long remain as an outstanding evidence of progress. It had been apparent to many in the Society for a few years prior to that date that there was a need for more assistance in the administrative work of the Society. The so-called radical, progressive element advocated a full time secretary with sufficient office assistance to cope properly with the increasing problems confronting organized medicine in the State. The more conservative reactionary members opposed any such change and were content to carry on with a part time member Secretary doing the work as best he could and where best he could. After the situation had been carefully studied by a special committee appointed by the President, a compromise plan was proposed and accepted by the House of Delegates. By this plan there were established three Secretaries, one of these being an Administrative Secretary, who would be a member of the Society on a part time basis, with an office equipped with a full time stenographer. The remainder of the Secretarial triumvirate included a Legislative Secretary and a Secretary on Scientific Work to act as Editor of the Journal.

This suggested change in administrative personnel was accepted by the House of Delegates and an increase in annual dues from four to five dollars followed. The new incumbent of the office of Administrative Secretary was our present Executive Secretary, Dr. Creighton Barker. The duties of this secretary have increased like the proverbial snowball and following the annual meeting of the Society in June 1938 we find him assuming, in addition to his other duties, those of Legislative Secretary. In the three years the work of the Executive Secretary's office was likewise increased beyond the conception of most of the members so that at the present time there are required in that office two full time stenographers as well as additional assistance at certain periods of the year. The budget of the Society, to keep pace with the re-

quirements of the administrative needs and of the monthly Journal, has been increased from \$7,125.00 for the year 1936-1937 to \$12,500.00 for the year 1938-1939. All this is in keeping with changes in the practice of medicine and in the proper administration of the duties which organized medicine has found itself obligated to assume throughout the entire country. It is not a question of how cheaply a State Medical Society can be managed today but of how efficiently it can carry on for the best interests of its membership. For several months it has been apparent to many who are cognizant of the facts that the demands made upon our part time Executive Secretary are such that it is physically impossible for one individual to meet them and at the same time pursue a private practice. His duties carry him far afield, for beside frequent trips to Hartford to attend hearings on bills pertinent to the practice of medicine or speaking in Bridgeport, Hartford, Waterbury and New London on the vital issues of medicine as they exist today, he is called to National Medical headquarters in Chicago, or to Federal headquarters in Washington. His ear must be ever on the ground and his finger on the pulse to detect every move in this swiftly changing order. If medicine is at the cross roads, as Dr. Van Etten, former speaker of the A. M. A. House of Delegates says it is, such an office or person is indispensable for the state organization and its individual members.

In many State Medical societies where there is large membership there will be found a full time secretary who receives a recompense commensurate with his services. Our Society must take a similar step if it is to continue to develop as it has during the last three years. Therefore, the Council is considering that the budget be increased to care for these needed developments. However, the ultimate decision must rest with each member through the component County Associations and through the House of Delegates of the State Society.

The Editor



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Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

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**NEWS.**— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

**ADVERTISEMENTS.**— All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

**SUBSCRIPTIONS.**— Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

**REPRINTS.**— Reprints of papers and obituaries may be obtained from the Editor at cost.

## • Editorials •

### THE REFUGEE PHYSICIAN

For years the problem of admitting aliens to the practice of medicine in the United States has plagued the various examining boards. In recent months, there has been added to this problem that of the refugee physician, a problem which threatens to dwarf the difficulties of the first.

While at present authentic figures as to the number of refugee physicians recently come to this country are not available, the number is conceded to be large. The examining boards of many states, justly, are becoming alarmed.

In New York, during the past month, legislation to bar aliens from practicing medicine was introduced in the Legislature. The Texas State Board of Medical Examiners, through its secretary, reports that the rapid influx of aliens may cause the Board to seek legislation requiring citizenship for taking the examination for medical licensure. Florida has adopted a resolution requiring each applicant for license to hold full citizenship and, in case of physicians graduating from foreign colleges, requires a senior year's work in a Class "A" American medical school.

Connecticut, New Jersey and New York, at present, require a declaration of intention to become a citizen of the United States before licensure and the New Jersey Board sets a limit of six years for completing naturalization requirements.

In 1928 the Connecticut State Examining Board removed the last Class "B" school from its accepted list and ruled that only graduates of Class "A" schools would be eligible for examination. Because of the great difficulty involved in checking foreign credentials, the Board further ruled that a graduate of any foreign medical school prior to 1919, whose school was not on the 1928 approved list, was not eligible for examination.

It would seem, therefore, that the problem of the alien physician, at least in so far as Connecticut is concerned, was being reasonably well handled up to the time of the influx of refugee groups.

How to deal with the additional problem now



presented is a question. The regulations of the Connecticut State Examining Board affecting foreign physicians should undoubtedly apply to the new group. But, whereas, formerly the foreign physician who came here did so of his own volition, the refugee physician has been forced to leave against his will and forced to find a haven.

The American tradition of equal opportunity to all requires that this group should not be discriminated against, but it would seem fair to enforce the following additional requirements for the protection of the sick and for the maintenance of the high quality of American medicine:

1. Establishment of a permanent residence, during which time the alien physician may perfect his English or receive instruction, if the language is new to him.

2. Declare his intention to become a citizen and secure second papers within six years.

3. Pass a creditable examination in the English language, because, as a physician, his status in the community is quasi-official.

The fulfillment of these requirements, in our opinion, will not impose undue hardships on a group admittedly already sorely beset.

### CANCER IN A RURAL COMMUNITY

The Association of Connecticut Tumor Clinics affords us a real contribution in cancer study, presented before a recent meeting of the Association in Willimantic and published in this issue of the Journal. The findings represent a statistical study of the cancer situation in the Windham Community Hospital for the past ten years. The study is a unique one, since this hospital serves a relatively rural area and 86% of the total cancer deaths in that hospital community were treated in that one hospital. This is in striking contrast to many other hospitals which receive and treat patients coming from outside the hospital community, in fact, from outside the State of Connecticut. This particular study of the cancer problem in the Windham Community Hospital area has produced considerable comment and evoked the commendation of the American College of Surgeons.

There are certain facts depicted in this report which will bear emphasis. For example, the percentage of population over 65 years in this particular area is 10, whereas for the entire state it is 5.5. The delay in treatment between

the visit to a physician and admission to the hospital in this area is 13.9 months, whereas in the New Haven hospitals it was found to be 15.4 months. Poor medical advice accounts for 22% of the cases of delay in reaching the hospital for treatment. This factor suggests possibilities for improvement by increasing post graduate education of the individual physician.

The Connecticut State Medical Society in cooperation with Yale University Medical School offers innumerable opportunities to the physicians of this state for improvement in the diagnosis of cancer. Upon the general practitioner must rest the responsibility for giving a large proportion of patients afflicted with cancer proper and timely advice. To these facilities are now added the work of the Association of Connecticut Tumor Clinics. Four clinics are held in different hospitals of the state each year and to these clinics are invited all the physicians of the State. The general practitioner and the internist are particularly urged to avail themselves of this opportunity. Cancer work in this state stands out because of the organized development and rapid progress it has made. These four clinics of the Association should be of inestimable value to all physicians in the State.

Advance notice of these clinics will be published in the Journal.

### THE COMING ANNUAL MEETING

On May 25 and 26 the 147th Annual Meeting of the State Society will be held at the Hotel Taft in New Haven. The program appears elsewhere in this issue. Your new program committee is introducing two features which should appeal to many. The scientific session the first day opens with a movie film, presented by Dr. Roy McClure of Detroit. This film has been received most favorably in several different cities of Europe as well as in this country. Each forenoon the papers presented will be discussed in summary by prominent invited guests. Except for these summary discussions all the papers will be presented by members of our own Society.

We are fortunate in securing the facilities of the Hotel Taft for the 1939 Annual Meeting. The central location of New Haven should make the meeting accessible to all. A commercial exhibit will be an important part of the meeting. There will be ample opportunity during the afternoons for friendly gatherings and in addi-

tion the section meetings are increasing in numbers and interest. The Hotel Taft will accommodate you over night if you make reservations early.

Date — May 25 and 26.

Place — Hotel Taft, New Haven.

### NO NATIONAL HEALTH INSURANCE THIS YEAR

Recent advices from Washington are to the effect that hearings on the medical and health phases of the Social Security legislation have been indefinitely postponed. The Committee on Ways and Means, before which these hearings are being held, finds itself in a protracted discussion of the Old Age Assistance part of the legislation and has delayed indefinitely the posting of any hearings on the health provisions. Apparently no bill covering medical care has been drafted. Some believe this may be due to a disagreement as to what department of the government should have the supervision and administration of health activities.

Underlying this sudden lack of activity along health insurance lines on the part of the government there would seem to be another very good and apparent reason. The American Medical Association at the last moment arose to the occasion and succeeded in making itself heard in the halls at Washington. Under the able leadership of its president, Dr. Abell, it is apparent to all that organized medicine has secured the ears of the Federal government and has been permitted to sit down in conference and not only discuss the problems of medical care but also contribute from its experience to the plans for solution. We may assume that we have gained an appreciable victory when we learn that it is now contemplated that whatever activities in the field of medical care are proposed will be subject to acceptance or rejection by the individual states. What would be suitable for Rhode Island obviously would not be suitable or practicable for Utah. There should be considerable satisfaction derived from the more promising outlook in health activities and medical care as they exist at Washington today.

### OBSTETRICAL CONSULTANT MONEY GOING BEGGING

At the last meeting of the Public Health Committee of the State Medical Society, Dr. Clifford of the State Department of Health reported that the fund set aside for obstetrical consultations was not being used. This money is now available for communities under thirty thousand population. It is the desire of the Public Health Committee that the funds be utilized more often than they are at the present time. It is your money handed over to the Federal government in taxes to be used in an effort to lower the maternal mortality in Connecticut, as well as in the other states. If you have a problem case in obstetrics in a community under thirty thousand you may have help and counsel only for the asking.

### MEDICAL EXECUTIVES UNITE

According to the January issue of Northwest Medicine, medical executives have united in the Northwest. On Dec. 4th at Portland, Oregon, the Medical Executives of the Northwest section of our country voted to form a Pacific States Medical Executives Conference. This conference includes responsible officers of the State Medical Associations of California, Oregon, Washington and Idaho and is being promoted as an idea of solving problems facing various state organizations in this region. As an organization it is to be fairly loosely knit, its action to be informal and its power only that of an advisory body. The first of these conferences was held in San Francisco in February 1938 and proved to be of sufficient value to warrant calling of the second meeting of the same groups before the expiration of the year.

A similar move has been contemplated on the eastern seaboard, the initiative coming from executives of the Medical Association of New Jersey. If this crystallizes Connecticut will be included and because of similar problems affecting this section of the East should be of some assistance in solving the same.

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# From the Secretary's Office

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## RESUME OF PENDING LEGISLATION

There are between 100 and 150 bills introduced in the present General Assembly that are of interest in one way or another to members of The Connecticut State Medical Society. These have all been reviewed by the Society's Committee on Public Policy and Legislation; some of the bills are of great importance, others not quite understandable in their import as yet, others of trivial or purely local interest.

### **An Act Concerning Examining and Licensing Boards and Commissions**

**Senate Bill 305**

**to Committee on Reorganization**

This bill, a copy of which has been sent to all members of the State Society, would consolidate the Medical Examining Board with twenty other professional and vocational examining boards in the newly created State Department under the direction of an executive secretary. The Connecticut State Medical Society and all other professional groups in the State are opposed to its passage.

### **An Act Concerning Medical Service Corporations**

**House Bill 857**

**to the Committee on Insurance**

A copy of this bill has been sent to all members of The Connecticut State Medical Society. It was introduced by the Society and would permit the eight county medical associations and the State Medical Society to incorporate for the purpose of providing medical service on a prepayment basis. In the investigation of the subject of prepaid medical service under the administration of medical associations it was found that existing Statutes would not permit medical associations to enter into such an activity. The legislation proposed would enable such associations when, as and if they choose, to embark upon such a program, providing contracts, rates, et cetera, were approved by the Commissioner of Insurance.

### **An Act Concerning Hospital Service Corporations**

**Senate Bill 57**

**to Committee on Insurance**

This bill was published in full in the January issue of The Connecticut State Medical Society's Journal and is enabling legislation governing the operation of non-profit sharing corporations providing contracts for prepaid hospital service. It was written by a sub-committee of the Governor's conference group on prepaid hospital service of which several members of the State Medical Society were members.

### **An Act Concerning a Serological Test for Syphilis in Pregnant Women**

**House Bill 294**

**to Committee on Public Health and Safety**

A copy of this bill has been sent to all members of The Connecticut State Medical Society. It was introduced by the Committee on Public Health of the State Medical Society.

### **Acts Concerning County Health Officers**

There are a group of bills introduced that propose to abolish the present system of having an attorney-at-law for the health officer in the eight counties of the State and to substitute therefor town health officers to be appointed by the Commissioner of Health. The prosecution for violation of public health laws, now carried out by county health officers, are to be made through the State's attorneys in each county.

### **An Act Concerning Nursing**

**House Bill 606**

**to Committee on Public Health and Safety**

A bill to revise existing laws concerning examination and registration of nurses.

### **An Act Concerning a State Board of Examiners for Physical Therapy and Allied Professions**

**Senate Bill 168**

**to Committee on Public Health and Safety**

This bill provides a board of three to examine and license practitioners of physical therapy and massage.



**An Act Amending the Medical Practice Act  
Concerning Requirements for Obtaining  
a Certificate of Registration for  
Medicine and Surgery**

**Senate Bill 173**

**to Committee on Public Health and Safety**

This bill would provide that no applicant shall be eligible for examination in medicine and surgery until he has received a degree of Doctor of Medicine. Under the present law osteopaths may be examined and licensed to practice medicine and surgery by the Connecticut State Medical Examining Board.

**An Act Concerning the Practice  
of Osteopathy**

**Senate Bill 931**

**to Committee on Public Health and Safety**

This bill provides that upon passing an examination osteopaths shall be entitled to practice in all subjects contained in the examination. The apparent intent of this bill is to allow osteopaths to practice medicine and surgery and obstetrics following an examination in those subjects by the Board of Osteopathic Examiners.

**Acts Concerning Medical Examination  
of School Children**

**House Bills 1224, 1233, 1236, 1239**

**to Committee on Education**

These bills have been introduced by a joint committee representing the Department of Education, the State Department of Health, the State Medical Society and the State Dental Society. The bills make more clear the purpose and scope of physical examination of school children and the sanitation of school buildings.

**An Act Concerning Medical Examining  
Boards**

**House Bill 1009**

**to Committee on Public Health and Safety**

This bill appears to reestablish the State Board of Examiners in Eclectic Medicine, a Board that has been non-existent for several years.

**An Act Concerning the Practice of  
Natureopathy**

**House Bill 1013**

**to Committee on Public Health and Safety**

This bill would allow natureopathic physicians to prescribe "tissue salts normally found in the human body and non-poisonous herbs."

**An Act Prohibiting Servants, Agents, Em-  
ployees or other Persons Connected Either  
Directly or Indirectly with Insurance Com-  
panies or Associations writing Liability In-  
surance from Discussing, Interviewing and  
Taking Statements of Persons Injured  
Prior to Ten Days from Date of Injury**

**House Bill 858**

**to Committee on Insurance**

The title of the bill explains its purpose.

**An Act Concerning Working Hours for  
Female Nurses**

**House Bill 983**

**to Committee on Labor**

This is a bill providing that any hospital receiving a State appropriation shall not allow any nurse or student nurse to work more than eight hours in any one day nor more than forty-four hours in any one week.

**An Act Concerning the Prevention and  
Treatment of Cancer**

**House Bill 1015**

**to Committee on Public Health and Safety**

This bill is introduced by the Tumor Committee of The Connecticut State Medical Society in conference with the State Health Commissioner and provides for an appropriation for the study of cancer within the State and the payment of hospital charges for indigent cancer patients.

**An Act Creating a State Department of  
Mental Hygiene**

**House Bill 1016**

**to Committee on Public Health and Safety**

This bill provides for the appointment by the Governor of a Commissioner of Mental Health to supervise and administer mental hygiene activities and remove such activities from the Bureau of Mental Hygiene of the State Health Department. (A substitute bill is likely to be introduced.)

**An Act to Aid Claimants for Workmen's  
Compensation**

**Senate Bill 320**

**to Committee on Judiciary**

This bill has been drafted by the members of the State Medical Society and has the approval of the chairman of the Committee on Medical Expert Testimony. It provides for the appointment by the Judges of the Superior Court of a physician who shall be the medical consultant to each of the five compensation commissioners and it shall be the duty of such consultant, at the

request of the commissioner, to investigate such physical and medical facts as may aid the commissioner in his decision.

**An Act Concerning Hospitals and Sanitaria**  
**House Bill 1025**

**to Committee on Public Health and Safety**

This bill provides that any person entering a hospital or sanitarium in this State as a private patient shall have the right to choose his own physician. Any institutions receiving State aid that deprives a person of this right shall be fined not less than \$500.00.

**Acts Concerning the Workmen's**  
**Compensation Act**

**House Bill 541, 898, 943**  
**Senate Bills 150, 262, 283, 319**  
**to Committee on Judiciary**

There are several bills amending the Workmen's Compensation Act that would increase the amount of weekly award made to injured workmen, increase the time such awards would be payable, defining occupational diseases and placing the burden of proof in occupational diseases on the employer.

**An Act Concerning Appointment of**  
**Temporary Commission to Study**  
**Necessity for Infirmary**  
**House Bill 1068**

**to Committee on Public Health and Safety**

This bill provides for a temporary commission appointed to study necessity of state infirmary for care of adult chronic diseases; care of aged married couples and indigent persons suffering from chronic disorders; to be appointed by governor. Five thousand dollars is hereby appropriated.

**An Act Concerning Hospital Charges in**  
**Workmen's Compensation Cases**  
**House Bill 1296**  
**to Committee on Judiciary**  
(Blank bill)

**An Act Concerning State Public Health**  
**Insurance**  
**House Bill 1451**  
**to Committee on Insurance**  
(Blank bill)

**An Act to Amend Section 2369 of the**  
**General Statutes of 1930**  
**House Bill 1526**

**to Committee on Reorganization**

This bill will provide a public health council of

eight members of whom at least one shall be a negro.

**An Act Concerning the Sale of Arch Sup-**  
**ports, Brace or Other Foot or Leg**  
**Appliances**

**Senate Bill 780**

**to Committee on Judiciary**

This bill provides for sale only when prescribed by orthopedic surgeon or state health commissioner.

**An Act Creating a Commission to Study and**  
**Investigate Health Insurance**

**House Bill 1495**

**to Committee on Public Health and Safety**

This bill provides for a commission of five members appointed by the Governor to investigate health insurance and report findings with recommendation for such legislation on or before January 1, 1941.

**An Act to Provide for the Payment of Treat-**  
**ment at the State Aided Hospitals by**  
**Relatives of Indigent Persons**

**Senate Bill 304**

**to Committee on Public Welfare**  
**and Humane Institutions**

This bill provides that any state aided hospital may bring complaint to the superior court against the relatives of any person unable to pay for treatment and the court may order the defendants to pay for the treatment.

**Compulsory Automobile Insurance**

Several bills have been introduced that would provide for compulsory automobile insurance. One hearing before the Committee on Motor Vehicles has already been held on these bills. The whole subject of compulsory automobile insurance is receiving consideration by a conference group appointed by the Governor of which the Secretary of this Society is a member.

Dates for hearings on most of these bills have not been assigned at this writing (February 14). Information as to the dates of the hearings may be obtained from this office or by communication with the Clerks of the Committees to which the bills have been referred. It is possible that some of the bills will be heard and rejected before the publication of this information. The legislative bulletins and calendars are available at this office and copies of some but not all of the bills.



# 147TH ANNUAL MEETING CONNECTICUT STATE MEDICAL SOCIETY

The program has been arranged by the committee in an effort to keep in mind the practical problems of practice. The meeting will open with the presentation of a film on the treatment of burns by Dr. Roy McClure of the Henry E. Ford Hospital, Detroit. This film has received approbation in London and Paris, as well as in other large cities, and will be presented by Dr. McClure in person unless unforeseen circumstances prevent. Problems of general surgery and a paper on general deformities will be discussed by Dr. Arthur Allen, Boston, and Dr. Thomas Lanman, Children's Hospital, Boston. These papers will not deal with surgical technique. In the same manner general medical papers will be discussed by Dr. Chester Keefer of Boston.

Those desiring over night accommodations at the Hotel Taft are urged to make reservations direct to the hotel and at an early date.

The program follows:

## May 25th, 1939

- 9-9:30 Movie—"Treatment of Burns"—Roy McClure, Detroit.
- 9:30 Treatment of Wounds—A. H. Bissell. Discussion.
- 9:55 Cholecystitis—Edward Ottenheimer. Discussion.
- 10:20 Essentials in Fracture Treatment—James Vickers. Discussion.
- 10:45 Summing-up Discussion—Dr. A. Allen, Boston.
- 11:15 Recess.
- 11:30 Symposium on Congenital Defects—Cleft Palate and Lip—C. C. Kelly.
- 11:45 Urogenital Deformities—H. Neuswanger.
- 12:00 Orthopedic Deformities—A. Griswold.

- 12:10 Neurological Deformities—Wm. German. Discussion.
- 12:30 Summing-up Discussion—Dr. Thomas Lanman, Boston.

## May 26th, 1939

- 9-9:30 Obstetrical Movie—"The Role of the Pelvis in Obstetrics"—Herbert Thoms.
- 9:30 Rational Therapy—Carl Wies. Discussion.
- 9:55 Vaccines of Value—S. S. Chipman. Discussion.
- 10:10 X-ray Fallacies—B. M. Parmelee. Discussion.
- 10:30 The Apical Cavity—R. G. Urquhart. Discussion.
- 10 minute Recess (?)
- 10:40 Treatment of Pneumonia—Francis Blake.
- 11:10 State Health Aspect of Pneumonia—Stanley Osborn.
- 11:35 Summing-up of above papers—Chester Keefer, Boston.
- 12:00 Rules and Regulations for Treatment of Cancer of Uterus.
- 12:00 Rules and Regulations for Treatment of Cancer of Uterus—J. R. Miller.
- 12:20 Dysmenorrhea—Carl Johnson.
- 12:40 Summary of Gyn. and Obs. papers.

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## CONVENTION OF MEDICAL STUDENTS

It is of interest to note that the 3rd annual convention of Medical Students recently met in Philadelphia. This new organization apparently is engaging the interest of the younger generation at the expense of many of the old line fraternal and social clubs and semi-philanthropic ventures. The Weekly Roster and Medical Digest of the Philadelphia County Medical Society considers this new organization a step in the right direction and believes that its great opportunity lies in separating future leaders in medicine and helping them to develop while they are young and enthusiastic.

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## SECTION ON Orthopedic Surgery

### Sacro-Iliac Joint Pain

Horace Gray, clinical professor of medicine, Stanford University, has contributed probably the most useful bit of research concerning this interesting syndrome since Goldthwait and Osgood's basic dissections some 25 years ago. His work appeared in *The International Clinics*, Vol. II, series 48, published by J. B. Lippincott Co., Philadelphia, a few months past. He initiates the return swing of the pendulum by definitely proving the existence of 1 to 3 mms. of motion at the ilio-sacral joints. He suggests manipulations without anesthesia in his treatment.

He quotes Sir Robert Jones to the effect that forcible manipulative surgery has been neglected by the orthopedist and hence it has fallen to the lot of the bone setter who has practiced it with success. This, he believes is a challenge and he proceeds to elaborate his thesis. It is well worth reading.

### Newington Home for Crippled Children

Additions to the surgical staff of Dr. Outerson and Dr. Buckley indicate a healthy growth of the organization and point to new and interesting work that is being done in the field of cerebral birth injuries and peripheral nerve surgery. With a well rounded staff and a fresh spirit of enterprise, which now exists, the institution should produce results which will be most gratifying.

Outpatient clinics are held on Tuesday mornings by Dr. Yergason assisted by Dr. Goff; Thursday morning by Dr. Pike, assisted by Dr. Jones and on Friday afternoon by Dr. Lindsay, assisted by Dr. Goff. On the first Wednesday of each month, at two in the afternoon, Dr. Lindsay, assisted by Dr. Goff, conducts one of the six State Social Security Clinics for Crippled Children. Newington Home boasts the only therapeutic pool in the state and has a large corps of trained physical therapists. A speech teacher was added a year ago to the staff, a field of re-

construction too often neglected. This constitutes a well rounded crippled children's program.

### German Medical Students

It is reported that the enrollment in German medical schools has fallen over fifty per cent in the past ten years. The course has been shortened one semester to make it more attractive.

### The Foot

by Norman C. Lake, M.D., 2nd., Ed.  
Bailliere, Tindall & Cox, London

From reviews published, this new edition appears to have merit especially for the orthopedist.

### Acute Anterior Poliomyelitis

Four cases were recently reported in England occurring simultaneously in school boys with the only common factors consisting of the same feeding arrangements and contact with the domestic staff. Strawberries are suggested as the food factor carrying the virus. Kling, of Sweden, has also presented evidence suggesting food as a possible route of infection in the spread of this disease.

### Lumbago and Sciatica, a New Hypotheses Concerning Etiology

Makaroff (*Industrial Medicine*, 8, 1, Jan. 1939) offers the suggestion that lumbagos and sciaticas are manifestations of vaso-spastic disorders. He reports a case in which an allergic reaction resulted in a cure of the lumbago.

### 11th Edition of Scudder's Fractures

Just off the press comes this monograph on fractures by Charles L. Scudder of Boston. So many editions attest to the reception this book has had in the past and apparently continues to enjoy.

### New York City Regional Fracture Committee Meeting of the American College of Surgeons

Drs. R. M. Yergason, Edwin Pyle and C. W. Goff discussed fracture problems on the program of the New York Fracture Committee, fourth annual meeting, held February 24, 1939, at the Lennox Hill Hospital, New York City.



## Our Neighbors

### MAINE

The University of Maine, in cooperation with the three largest hospitals in the State, has started a five-year combined course in liberal arts and nursing which leads to a bachelor of arts degree and a hospital diploma.

Completion of the course will make the student eligible to take the State examinations for the registered nurse degree. It is expected to help relieve the great need for public health nurses which State officials have emphasized. Eighteen women students are now enrolled in the course.

Cooperating are the Maine General Hospital in Portland, the Central Maine General Hospital in Lewiston, and the Eastern Maine General Hospital in Bangor. Most responsible for the course are Dean Edward J. Allen of the College of Arts and Sciences, Professor Joseph Murray, head of the Zoology Department, and the heads of the hospitals.

The program provides for attendance at the university during the first and second years, the Fall semester of the third year and the Spring semester of the fifth year. Preliminary training will be given at the hospitals during the Summer sessions which follow the first two college years, and these sessions will constitute a probation period.

Beginning with the Spring semester of the third year the student will attend the school of nursing at the hospital with which she affiliates. She will complete her hospital training of two years before returning to the university for her final semester.

The student's program of study at the university includes basic courses in English, foreign language, sociology, economics, several psychology courses, chemistry and biology, totaling a little more than ninety credit hours.

Dr. Allan Craig, Medical Director, Eastern Maine General Hospital, Bangor, and formerly Superintendent of the Charlotte Hungerford Hospital, Torrington, Connecticut, is the author of a paper entitled, "The Doctor, Family Friend

or Public Servant," appearing in the February issue of the Journal of the Maine Medical Association.

### NEW JERSEY

The Medical Society of New Jersey has now completed just five years with established executive and editorial offices. The record of the accomplishments of these five years has appeared in that Society's Journal. At the time the offices were established it was difficult to obtain enough creditable material for publication in the Journal. Now, like most other active societies it is difficult to cull out the wheat from the chaff. Five years ago the county societies chafed under the dominance of the State Society; now there is most hearty cooperation between county and state organizations.

### NEW YORK

New York State has more physicians in proportion to population than other states, and many more than European countries, it was announced today by Dr. Joseph S. Lawrence, executive officer of the Medical Society of the State of New York, whose study of the distribution of physicians was made public in the February 1 issue of the New York State Journal of Medicine, official organ of the society.

The conclusions drawn by Dr. Lawrence from the data presented with his published article, are:

1. Resident physicians and hospitals are distributed throughout the state in such fashion that no area is without medical service. Schuylar County has the highest ratio of physicians to population, 1:1298, and the lowest is in Dutchess County, 1:478. In the relation of general hospital beds to the population, the highest is found in Livingston County, 1:1644 and the lowest ratio exists in Ontario County, 1:84. In evaluating these figures, it must be borne in mind that no county is an isolated unit, so that the services of physicians and hospitals of neighboring counties are always available.

2. Improved conditions for transportation and communication in the rural districts have increased the usefulness of the physician many times over what it was ten years ago.

3. The same conditions have led the rural resident to seek the services of the city physician except for emergencies. In some instances this trend has induced rural physicians to move to

the cities, at the same time retaining their rural practices.

4. Improved living conditions are attracting young men to locate in the rural areas.

5. There is no marked difference in the ages of the men practicing in the rural districts as compared with those in the urban districts.

6. Decreases in population must be marked and prolonged before there is any effect upon the number of physicians. Areas of growing population have larger proportions of young physicians.

7. Nursing service as a part of a public health program demands prompt study.

Westchester County is formulating a plan to provide home nursing at \$3.00 a year per family. The Westchester County Nursing Council has been incorporated with a board of trustees composed of representatives of the various visiting nurse agencies who will furnish the service as required. The county medical society has approved the plan for the purpose of an experiment.

#### RHODE ISLAND

At the December meeting of the Providence Medical Association, Dr. David R. Lyman of Wallingford, Connecticut, addressed the association on "Early Diagnosis of Tuberculosis."

#### VERMONT

Governor Aiken, in his message to the legislature recently, expressed his opposition and that of his state to any plan for medical care which would permit political selection of doctors or the direction of their activities by the government. He did express his willingness, however, to cooperate "with the people of other states or with the federal government on any plan providing for cooperative and voluntary efforts to promote better health among our citizens." He believes that if some plan is devised for improving the present scope of medical care in Vermont and legislation is necessary to make it effective, such legislation should be enacted.

## - NEWS - *from County Associations*

#### Fairfield

Dr. Henry E. Waterhouse, Bridgeport, died on February 4, 1939 of coronary occlusion, after an illness of two days. After graduation from Columbia University Medical School, Dr. Waterhouse began practice in Bridgeport in 1905 and joined the staff of the Bridgeport Hospital. He gradually limited his practice to obstetrics and became chief of the obstetrical service of the Bridgeport Hospital in 1915. His unexpected departure, after so brief an illness, occasions sincere sorrow in many homes, as well as to the profession he loved.

Dr. Creighton Barker, Administrative Secretary of the State Society, addressed the members of the Bridgeport Medical Society on February 7th on the subject of the National Health Program. Dr. Barker's presentation of this material in his usual scholarly manner evoked enthusiastic discussion. He also outlined the bills, pertaining to medicine, that are to be presented at this session of the State Legislature.

Dr. Ashley Oughterson, Associate Professor of Surgery of Yale University Medical School, spoke before the combined Fairfield County and Norwalk Medical Associations on February 8th in Norwalk. The discussion of the subject, "Carcinoma of the Stomach", was opened by Dr. J. W. Hinton of New York City and Dr. W. S. Stone of Norwalk and stimulated interested general discussion from the floor.

#### Hartford

On January 18, 1939, at the Annual Meeting of the Staff of St. Francis Hospital, Dr. Edward J. Turbert, a former President of the Hartford Medical Society and Vice-President of the Staff of St. Francis Hospital for several years, was elected President of the Medical Staff. Other

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officers elected were as follows: Dr. Thomas F. Welch, Vice-President; Dr. F. Arthur Emmett, Secretary; Dr. Thomas P. Moylan, Treasurer and Dr. John F. McDermott, Assistant Secretary.

Various opportunities for what might really be construed as post-graduate study which can be pursued in an easy manner, are offered by clinics at the various hospitals in the city of Hartford and members of the County Medical Society are urged to take advantage of these opportunities. The Medical Information Bureau has recently sent circulars to members of the City and County Medical Societies containing a list of the special clinics to which they are cordially invited and schedules of the hospital rounds, etc. Some of these clinics have been established for a long time but it has not been directly called to the attention of the members frequently enough. Particularly to be recommended are the special clinics at the Hartford Hospital and the so-called Wednesday Morning Clinics at St. Francis Hospital. By attendance at these clinics, one may have the chance to carry on one form of post-graduate study and see many interesting conditions and diseases.

On February 6, 1939 at the Hartford Medical Society, a large audience heard a very interesting and practical lecture on the "Diagnosis and Treatment of Acute Head Injuries", by Donald Munro, M.D., Assistant Professor of Neuro-Surgery, Harvard University School of Medicine, Associate Professor of Neuro-Surgery, Boston University School of Medicine, Boston, Massachusetts.

On January 3, 1939 at the Annual Meeting of The Hartford Medical Society the following were elected to the various offices: Howard W. Brayton, President; Arthur B. Landry, Vice-President; Thomas C. Carey, Secretary; David Gaberman, Assistant Secretary; Franklin L. Lawton, Treasurer; Clinton D. Deming, Assistant Treasurer; Walter R. Steiner, Librarian and Ernest Caulfield, Assistant Librarian.

The engagement of Miss Ruth Larson of Hartford to Dr. William Stevenson of Bristol has been recently announced.

Dr. Raymond Glazier of Hartford has given up private practice to assume his new duties as Assistant Medical Director of the Hartford Hospital.

## Litchfield

Dr. J. Jenry Kott has removed his office from 199 Main Street to 18 Pearl Street, Torrington, Conn.

Ex-president of the Connecticut State Medical Society, Charles H. Turkington of Litchfield, remained in the Charlotte Hungerford Hospital for a period of one week during the past month. A minor surgical procedure necessitated his hospitalization.

## Middlesex

A special committee consisting of Professor Schneider, chairman, E. Kent Hubbard and Charles A. Russell, all members of the Board of Directors of the Middlesex Hospital, submitted the following recommendations which were accepted at the meeting of the Board of Directors held on January 5:

"(1) That voting privileges in the Medical Board be limited to the members of the Senior Attending Staff.

"(2) That a Medical Advisory Council of seven be established; its membership to include the President of the Board of Directors, ex-officio, the president, vice-president and secretary of the Medical Board, and three other members of the Medical Board appointed by the Board of Directors upon nomination by its nominating committee.

"(Note: The Nominating Committee will be prepared to nominate to the Board of Directors the 3 members of the Medical Advisory Council to be appointed by the Board of Directors, as soon as the officers of the Medical Board are elected for the coming year.

"(3) That staff appointments be made annually by the Board of Directors, normally upon the recommendation of the Medical Advisory Council through the nominating committee.

"(4) That for at least the current year the number of surgical teams remains as at present. That thereafter only surgeons be appointed who if possible have membership in the American College of Surgeons.

"(5) That for the current year all staff appointments be approximately the same as now.

"(Note: The Nominating Committee in presenting nominations for the Medical Staff for the current year at the meeting of the Board of Directors on Jan. 5 were guided by the recommendations Nos. 4 and 5.

"(6) That the applicant for privileges in the hospital shall submit to the Superintendent his request. Upon receipt of such request the Superintendent shall submit it to the Medical Advisory Council, which shall investigate the training, experience and fitness of said applicant and make recommendation to the Board of Directors as to the acceptance of the applicant's petition. Applicants for surgical privileges are to be recommended in so far as possible in accordance with the requirements of the American College of Surgeons. The Medical Board is to establish the method of procedure. The granting of hospital privileges to be by the Board of Directors upon recommendation of the Medical Advisory Council.

"Note: The phrase "the Medical Board is to establish a method of procedure" is interpreted to mean that they may discuss the applicant for privileges in a full board meeting, or refer the matter with power to the Medical Advisory Council, or take any other action in their opinion desirable, but the Board of Directors will recognize recommendations as official only when coming from the Medical Advisory Council."

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#### New Haven

At its annual meeting on January 18 the New Haven Medical Association elected the following officers to serve during 1939: President, Dr. Robert G. Tracy; Vice-President, Dr. Axel P. Bergman; Recording Secretary, Dr. William J. Dennehy; Financial Secretary, Dr. Ralph W. Nichols; Treasurer, Dr. Charles E. Sanford; Executive Committee, Dr. Willis E. Hartshorn, Dr. John F. Sullivan; House Committee, Dr. Maxwell Lear, Dr. L. C. Foster. Literary Committee, Dr. Benedict R. Harris; Finance Committee, Dr. Thomas J. Sullivan.

The first meeting of the New Haven Medical Association in February was addressed by Dr. Hugo Roesler, Associate Professor of Roentgenology and Cardiology, Temple University, on "The Relation of the Heart to Pulmonary Disease."

At the second February meeting Dr. Thomas Francis, Jr., Professor of Bacteriology, New York University Medical School, presented a report of "Studies in Epidemic Influenza."

On December 15, 1938, the Waterbury Medical Society conducted a public forum at the Medical Association Building. Dr. Ernest M.

Daland of Boston, chief of staff of the Pondville State Cancer Hospital addressed the forum on the subject of "The Nature and Control of Cancer". The paper was discussed by Dr. Charles L. Larkin and Dr. E. H. Kirschbaum.

On January 5, 1939, the Waterbury Mental Hygiene Society sponsored a talk open to the public at the Waterbury Medical Society building by Dr. Lawson G. Lowrey on the subject of "Mental Hygiene and Delinquency."

On January 12, 1939, the annual meeting of the Waterbury Medical Association was held at the Waterbury Medical Society Building. Dr. Edward Herr was elected President; Dr. John S. Dye, Vice-President; Dr. Andrew C. Swenson, Treasurer; Dr. Henry J. Stettbacher, Secretary; and Drs. Walter Barber and P. J. Brennan were elected to the Executive Committee. The retiring President, Dr. J. Harold Root, gave an address on "The History of New Pure Food and Drug Act". After the annual dinner the society was addressed by Dr. R. G. Leland, Director of the Bureau of Medical Economics of the American Medical Association.

On January 19, 1939, the Waterbury Medical Association presented a public forum at the Waterbury Medical Association building. The guest speaker was Dr. Harold Marvin of Yale who spoke on the subject of "Heart Disease". The paper was discussed by Dr. John Foster and Dr. Irving Platt.

At the regular monthly meeting of the Yale Medical Society held on Wednesday, February 8th in the Sterling Hall of Medicine, the following program was presented: The conduction of pain in the fifth nerve and its bearing on the treatment of trigeminal neuralgia. Presented by Olof Sjoqvist. Serum lipoids in hypothyroidism, The measurement of creatine tolerance; a possible role of glycine in creatine studies, by A. E. Wilhelmi. A study of infant mortality in Caesarian Section by Herbert C. Miller.

Analysis of the statement of operations of the Grace Hospital of New Haven for the year ended December 31, 1938 reveals that the average per diem cost for the care of patients was \$5.77. The average per diem earning was \$5.02. Earnings from patients amounted to \$348,601.28. The operating expenses were \$419,919.68, leaving an operating deficit of \$71,318.40, which was offset by income from the Community Chest, the



State, endowment earnings and contributions, leaving a final net deficit of \$22,214.60. About 45% of the total number of patients hospitalized were cared for in the wards, where they were charged only about 40% of the cost of rendering service.

Death claimed 3 notable physicians from New Haven County since the beginning of the year.

Dr. Leonard Woolsey Bacon died in his 74th year at his home on January 8.

Dr. James A. Harten died in his 53rd year at his home on February 6.

Dr. Charles FitzGerald died in his 62nd year on February 9 after a brief illness.

A new series of health talks under the title, "Education in Health," is being presented through station WICC, each Friday afternoon at 3:30 under the auspices of the New Haven Medical Society. The first of this series of radio broadcasts was given on February 3 by Dr. Barnett Greenhouse, his subject being, "Health For Health's Sake". The purpose of these broadcasts as stated by Dr. Greenhouse, chairman of committee on radio broadcasts, "is educational with an aim to counteract the prejudiced medical information with which the public is swamped by promoters for self-gain; and to assert the leadership of the physician in matters pertaining to health."

The City of New Haven has continued to maintain a favorable health record during the year 1938. Both the infant and maternal mortality rates have dropped to new low marks for the city. The infant mortality rate of 22.1 is a record both for the city and the country. There were 66 resident deaths from tuberculosis during 1938, giving the city a mortality rate of 40.6 per 100,000 for this disease. The city's total births climbed again in 1938 from 2,107 in 1937 to 2,265. Both heart disease and cancer claimed more deaths in 1938 than in 1937. There were but two deaths from the common communicable diseases, one each from typhoid fever and from whooping cough.

## New London

The New London City Medical Society held its annual meeting at the Mohican Hotel, January 26th. A business meeting was held with election of officers as follows:—

President, Richard Starr; Vice-President, E. K. Devitt; Secretary and Treasurer, Helen Ferguson; Curator, Hill F. Warren; Executive Committee, Thomas Murray, George Cheney, Robert Hemple.

Dr. Frank Dunn returned home from the Lawrence and Memorial Associated Hospitals, New London, where he has been confined for some time with illness. He expects soon to resume his practice in his home.

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# The Doctor's Office

Ernest F. Gordon, M.D., has relinquished his practice at 31 Howe Street, New Haven and established himself in practice at 27 Ludlow Street, Yonkers, N. Y.

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Thomas E. Shaffer, M.D., announces the opening of his office at 303 Whitney Avenue, New Haven, for the practice of Pediatrics. Dr. Shaffer was located formerly in Farmington.

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### HEZEKIAH BEARDSLEY CLUB MEETS

The winter meeting of the Hezekiah Beardsley Pediatric Club was held on December 8 at the Newington Home for Crippled Children. The members of the club were impressed by the good work being done at the Home. A program of clinics was arranged by Dr. John Griggs and this was followed by a splendid dinner, during which the guests present were entertained with several selections by the childrens' orchestra and by the chorus.

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## SPECIAL NOTICES

### Philadelphia Academy of Surgery THE SAMUEL D. GROSS PRIZE Fifteen Hundred Dollars

Essays will be received in competition for the prize until  
January 1, 1940

The conditions annexed by the testator are that the prize "shall be awarded every five years to the writer of the best original essay, not exceeding one hundred and fifty printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice founded upon original investigations, the candidates for the prize to be American citizens."

It is expressly stipulated that the competitor who receives the prize shall publish his essay in book form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery, and that on the title page it shall be stated that to the essay was awarded the Samuel D. Gross Prize of the Philadelphia Academy of Surgery.

The essays, which must be written by a single author in the English language, should be sent to the "Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 19 S. 22d St., Philadelphia," on or before January 1, 1940.

Each essay must be typewritten, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

Edward B. Hodge, M.D.,  
Charles F. Mitchell, M.D.  
Calvin M. Smyth, Jr., M.D.  
*Trustees*

### EXAMINATIONS BOARD OF OBSTETRICS AND GYNECOLOGY

Application for admission to the Group A, May 1939, Board examinations must be on file in the Secretary's Office not later than March 15, 1939.

The general oral, clinical and pathological examinations for all candidates, Part II Examinations (Groups A and B), will be conducted by the entire board, meeting in St. Louis, Missouri, on May 15 and 16, 1939, immediately prior to the annual meeting of the American Medical Association. Notice of time and place of these examinations will be forwarded to all candidates well in advance of the examination dates.

Candidates for re-examination in Part II (Groups A and B), must request such re-examination by writing the

Secretary's Office before April 1, 1939. Candidates who are required to take re-examinations must do so before the expiration of three years from the date of their first examination.

The annual dinner meeting of the Board to which all Diplomats and candidates are invited, as well as their wives and others interested in the work of the Board, will be held at the Congress Hotel, St. Louis, on Wednesday evening, May 17, following the close of the examinations.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, (6) Pennsylvania.

### INTERNATIONAL ASSEMBLY OF INTER-STATE POSTGRADUATE MEDICAL ASSOCIATION OF NORTH AMERICA

The 1939 International Assembly of the Inter-State Postgraduate Medical Assembly of North America will be held in the Palmer House, Chicago, Illinois, October 30 to November 3, inclusive. Reservations may be made now by writing directly to the Palmer House.

### FIFTEENTH ANNUAL EUROPEAN ASSEMBLIES

The Annual European Assemblies of the Inter-State Postgraduate Medical Association of North America will be held this year from May 17 to July 11. The itinerary includes visits to the following countries: England, Ireland, Scotland, Norway, Sweden, Denmark, Holland, Belgium, Switzerland and France. The price of Assemblies on the All-Expense plan is — Cabin rate, \$1195 per person; Tourist rate, \$1095 per person. Further information may be obtained from the Manager of Travel Department American Express Company, New York City.

### MAY DAY — CHILD HEALTH DAY, 1939 Monday, May 1

Child Health Day activities are sponsored by the Children's Bureau at the request of the State and Provincial Health Authorities of North America in accordance with the Congressional Resolution of May 18, 1928, which authorized the President to proclaim May Day as Child Health Day.

Slogan: The health of the child is the power of the nation.

Objective: To bring to the attention of each community —

The importance to the child's health, development, and well-being throughout life, of proper food, rest, exercise, medical care, and protection against disease.

The ways of informing parents and others how child health may be safeguarded, and

The means whereby such safeguards may be made available for all children.



## Letters to the Editor

NATIONAL LIBRARY OF PEIPING  
Kunming, China

December 15, 1938

To the Editor:

Ever since Japan's military occupation of Peiping, all national institutions of learning in that historical city have been unable to function. In view of this situation, we have established an office at Kunming, Yunnan. We have been collecting books and journals in order to meet the intellectual needs of Chinese scholars in this hour of distress. As many of our universities and scientific institutions have been deliberately destroyed by Japanese militarists, the need of scientific literature felt by Chinese scholars is especially urgent at the present time.

In order to keep Chinese scholars informed as to the recent development of various branches of science, we are building up a special Reprint Collection which will be of great value to investigators engaged in scientific research.

Knowing that your institution has made notable contributions to learning and cognizant of your intellectual sympathy for China, we earnestly hope that you will find it possible to ask each member of your scientific staff to send us a complete set of his reprints if they are still available for distribution.

As we have to start our work entirely afresh, we are in urgent need of books and periodicals of all kinds, old or new, especially standard works in various fields. Donations of books from American and Canadian authors may be sent to us care of the International Exchange Service, Smithsonian Institution, Washington, D. C., which makes monthly shipment to China. Should any of your friends be willing to lend a helping hand in the rehabilitation of our collections, will you kindly make the necessary contact for us?

As a great deal of scientific work is being carried on in China in spite of the war, your contributions will render a great service to the present and future generations of intellectual workers in this country.

Thanking you in anticipation for your kind cooperation and assistance,

Yours faithfully,

T. L. YUAN,  
Acting Director.



## • OBITUARIES •

FRANK L. WAITE, M.D.

1866 - 1938

It is with deepest regret that the Hartford County Medical Association finds it necessary to record the passing of one of its prominent members, Dr. Frank L. Waite who has been a member of this society since April 18, 1894.

He was a man of the highest quality and very conscientious in his duties. He was very devoted to his work which was his greatest pleasure at the same time. He served the Hartford Hospital from 1899 to 1931 actively and as consultant from 1931 to his recent illness. He was formerly a member of the Staff of the St. Francis Hospital from 1897 to 1914.

Therefore, we place upon our records these words as a monument to his memory that those who remain after him may know the high regard in which he was held by his fellow members.

W. L. Gills, M.D.



LEONARD WOOLSEY BACON, M.D.

1866 - 1939

Leonard Woolsey Bacon, M.D., was born in Stamford, Connecticut, in 1866. His early education was obtained in Europe and the United States. He attended Amherst College, University of Pennsylvania, and University of Leipzig. He graduated from Yale, Class of 1888 and from Yale Medical School, Class of 1891. He practiced medicine and surgery in the city of New Haven for forty-seven years. This period of practice was interrupted twice; first, by a year of post-graduate study with Theodore Kocher at Berne, Switzerland and at the University of Tubingen, and second, by a period of meritorious

service in the World War. In 1917 he enlisted and received the rank of Major in the medical corps. After the termination of his service in the regular army he joined the Veteran's Bureau and was in charge of the surgical staff of the Allington Hospital, New Haven, Connecticut, for a period of several years.

He was honored by his associates and was Vice-President of the State Medical Society, President of the City Medical Association and of the Yale Medical Alumni Association. During his years of service he was attending surgeon at Grace and St. Raphael Hospitals, New Haven, and instructor in medicine in Yale Medical School. In later years he devoted himself more particularly to orthopedic surgery and became a well known authority in this field.

He made numerous contributions to medical and surgical literature. He personally trained a considerable number of our leading surgeons, very much in a tutorial manner, taking his assisting surgeon with him into the home where he did a great deal of his surgery in the early days. Aside from his medical knowledge he was a great student of the languages, a walking encyclopedia of history, and a musician of very considerable attainments both in composition and performance.

His medical friends will miss his keen judgment, kindly spirit, and delicate sense of humor.

Theodore S. Evans, M.D.



## LIFE EXTENSION EXAMINERS PUBLISH A NEW MEDICAL PERIODICAL

Life Extension Examiners, an outgrowth of the Life Extension Institute, is now publishing "Proceedings of the Life Extension Examiners," a bi-monthly Journal in which is set forth information which it considers of value for its 3000 Examiners throughout the United States and Canada. It has organized a research department with the editor of this periodical as director. The majority of its pages will be devoted to Scientific proceedings to include preliminary reports of studies and progress, abstracts of articles published by that corporation and suggestions regarding technic, methods of procedure, etc. It is intended to be a valuable contribution in the development of periodical health examinations.

## • Quarto Notes •

### SYNOPSIS OF DIGESTIVE DISEASES

by John L. Kantor, Ph.D., M.D.

Associate in Medicine, Columbia University  
Gastroenterologist and Associate Roentgenologist  
Montefiore Hospital for Chronic Diseases, New York  
286 pages 40 illustrations \$3.50  
St. Louis C. V. Mosby Co. 1937

As one reads and rereads this small book of less than three hundred pages one realizes what a wealth of material has been packed into a small space, presenting the essential facts concerning diseases of digestion, simple, clearly and concisely.

The subject matter is well organized into three main groups of digestive disorders under the following heads:

1. Those due to constitutional digestive inferiority.
2. Those due to acquired digestive disease.
3. Those due to extra digestive disease.

Illustrations are freely used to help clarify many descriptive paragraphs.

Far from being a simple theoretical review of digestive diseases this book is a very practical one for reference use. For example detailed diets are presented under the following headings:

Standard Bland, Convalescent, Ulcer, Ulcerative, Colitis, Intestinal, Protein, Constipation, Sippy and High Vitamin Diet, etc.

Chapter IV correlates digestive disorders with pathology elsewhere than in the digestive tract, making the book of interest to those not primarily interested in gastroenterology.

M. O. Phelps



## INTERNS HANDBOOK

A Guide, especially in Emergencies for the  
Intern and the Physician in General  
Practice

by Members of the Faculty of the College of Medicine  
Syracuse University  
Under the direction of  
M. S. Dooley, A.B., M.D.

Chairman Publication Committee

2nd Edition 523 pp. \$3.00  
Phila. J. B. Lippincott Co. 1938

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J. C. Rowley

## MEDICINE IN MODERN SOCIETY

by David Reisman, M.D.

President, American Society of Medical History

226 pages

\$2.50

Princeton, N. J. Princeton University Press 1938

The author, believing that "The History of Medicine is in reality an epitome of the history of civilization and that it should form a part of every man's culture," developed this book from a series of lectures known as the Vanuxem Lectures which he had the honor of delivering at Princeton University. In undertaking this work he has ably and yet concisely presented a history of medicine that will interest both layman and physicians. The volume might well be used as a textbook should the time come to broaden the educational basis of our youth in high school and college by giving them survey courses in the history of medicine analogous to those given in the history of art. The "peaks" in medical history are touched upon and include discussion of interesting topics such as opium, the circulation of the blood, modern concepts and treatment of scurvy, vaccination, anesthesia, transmission of disease by insects, antitoxins, X-ray, radium, insulin, psychoanalysis, vitamins and viruses. Many other topics of general interest are dealt with in an interesting manner. The false gods that people have followed in medicine — superstition, quackery, astrology, witchcraft, alchemy, the cults — are depicted in their true light. The question of medicine as a career is discussed and the function of the family doctor as a coordinator of the opinions, that the various specialists may give, is stressed. A chapter is devoted to medical ethics and another to preventive medicine. In Chapter 14 "The social outlook in medicine" is

discussed in a very straightforward fashion. The complexity of the problem is indicated and the advisability of accepting or rejecting certain plans is stated. The conclusion is reached that the organized medical profession must take the lead in the inevitable movement of reform or, failing in that, it will be obliged to follow those who have neither the knowledge, the wisdom, nor the incentive to preserve what is best in American medicine. A very worthwhile book that a physician should have for reference and in which the layman will find a real and lively interest.

R. M. Tovell

## TRAUMA AND INTERNAL DISEASE

Frank W. Apicer, A.B., M.D., F.A.C.P.

593 pages

43 illustrations

J. B. Lippincott Company

1939

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In an age where travel at the rate of 88 feet per second is a common occurrence in every-day life, the question of trauma is an important consideration in many purely medical cases. Daily in the various courts of law the question is raised, "what part does trauma play in this disability?" For the physician who may be asked this question, and no practicing doctor is exempt, this book will prove valuable and interesting.

It is the result of a thorough and wide review of the literature — most of it foreign — dealing with the relationship between disease and trauma. Diseases of the different systems of the body are considered in turn, starting with "Trauma and the Brain" and taking up the various organs, systems and diseases in a very orderly fashion to the final chapter on the controversial subject, "Trauma and Tumors".

There is a wealth of illustrative cases in each instance, and every section is furnished with a good list of references. In order to cover the whole field of internal medicine, the discussion of each disease or organ is concise. Furthermore, as an aid to rapid grasp of the situation, there is a terse paragraph of summary at the end of each chapter.

Some of the disease entities that may be attributed to trauma are not usually considered to be related to injury, but case reports presenting strong evidence are quoted. Among the large list of diseases in which the possibility of trauma as an etiological agent is generally overlooked are hypertension, disseminated sclerosis, Frolich's syndrome, tuberculosis, heart block, peptic ulcer, appendicitis, nephritis, renal stone, diabetes mellitus, leukemia and Graves' disease.

This book in attempting to cover a tremendous field has omitted several obvious diseases directly resulting from trauma. There is no mention of the medical conditions in later life that are directly attributed to trauma at birth. In describing trauma to the esophagus, no mention is made of injury resulting from esophagoscopy and other instrumentation — a common cause of mediastinitis. Finally, in describing brain tumors resulting from trauma, no mention is made of the striking relationship between trauma and meningiomas which Cushing emphasizes in his great work on meningiomas. No attempt is made to discuss treatment, since this book deals solely with the role that trauma may play in the production of internal disease.

W. F. Smith

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2. Lack of proper rest and sleep, dancing, and late hours to bed.
3. Under-clothing and chilling of the lower parts of the body, which allows pelvic disturbances to develop, especially abnormal menstruation.
4. Cigarette smoking, so likely to become excessive in young girls.
5. Not infrequently, cocktail drinking.

Physicians, parents and teachers must take notice.



## DEADLY SUBSTANCE HAS BEEN FOUND IN DRUG "CAUSALIN"

The Council on Pharmacy and Chemistry of the American Medical Association has found that the drug "causalin," recommended by the distributor for the treatment of arthritis, contains aminopyrine, which causes decrease in the granular white blood cells.

V. J. Dardinski, M.D., and E. Stuart Lyddane, M.D., Washington, D. C., report, in *The Journal of the American Medical Association* for Jan. 14, a case of agranulocytosis which they believe was caused by this drug.

The patient died on the day of admission to the hospital. He was admitted in a semicoma, but the history obtained from his family revealed that he had been taking causalin tablets for his arthritis for four months. The definite number of tablets taken could not be determined, but it was believed that he had taken well over 100. There have been many reports of death from proprietary medicines containing amnoi-pyrine.



## THE NEW YORK WORLD'S FAIR OPENS SOON

Unusual and dramatic exhibits for the Hall of Man in the Medical and Public Health Building at the New York World's Fair 1939 have been approved by the Fair's Board of Design. Creation of the Hall of Man has been made possible through the sponsorship of eight prominent insurance companies which pledged \$123,000 to the American Museum of Health for that purpose and the provision of a notable setting for the famous Oberlaender Trust exhibits in the field of human physiology.

What is likely to prove the most startling exhibit in the numerous collection of physiological displays is "The Talking Skeleton." It is a full-size human framework which once walked the earth "even as you and I." It stands in a glass cabinet against a black panel in an easy attitude. When the time comes for it to do its "turn," the skeleton is slowly floodlighted. It remains quite still awaiting its cue. Then, all at once it begins to breathe, takes three or four deep breaths and then the jaws open. In a neighborly voice it speaks to those gathered about.

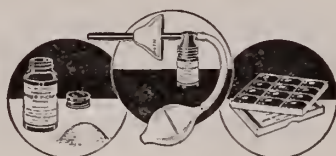
A list of special days has been assigned by the Fair. For example, May 19 is Connecticut Day, Middlesex County (Conn.) Day, and also the special day for the Illuminating Engineering Society, the Queens County Dental Society and for the Tenth International Congress of Military Medicine and Pharmacy. Special days for the other counties besides Middlesex are May 15, Fairfield; May 17, New Haven; May 22, Litchfield; May 24, Hartford; May 29, Tolland; May 31, Windham. Nowhere do we find mention of New London County.



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## CHIROPRACTIC MENACE DEFEATED

(Concluded from Page 117)

defeated by a majority of more than three to one. We were especially pleased at the decisive result as it probably precludes any repetition of this activity upon the part of the chiropractors during the coming session of the legislature.

In spite of the overwhelming defeat of this measure in Colorado, it is probable that a repetition of the effort will be made in some other state within a few years. It is on this account that it is worthwhile to let the members of the Connecticut State Medical Society know the type of campaign which proved successful in our hands. We trust that no other society may have to waste its energies in similar activities, but the public health must be protected and it is apparently the duty of the organized medical profession to provide this protection.

We feel the success of our endeavors is due to the following factors: first, the fact that, prior to the need for assistance, we had developed an

alliance of all groups which are primarily interested in maintaining high health standards; second, wide spread publicity, using press, radio, pamphlets and public speakers in an endeavor to reach all the voters; third, the active and interested cooperation of the private physician to reach and influence his individual patients and inform them of the menace to public welfare inherent in the movement.

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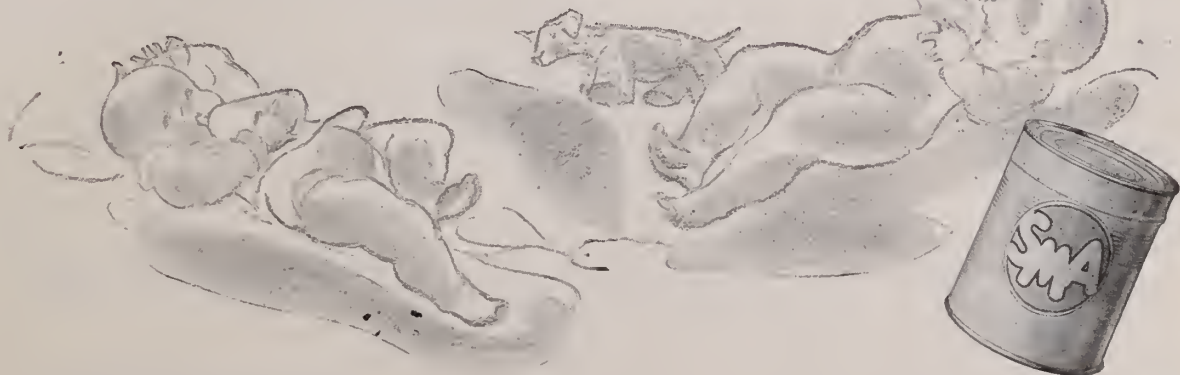
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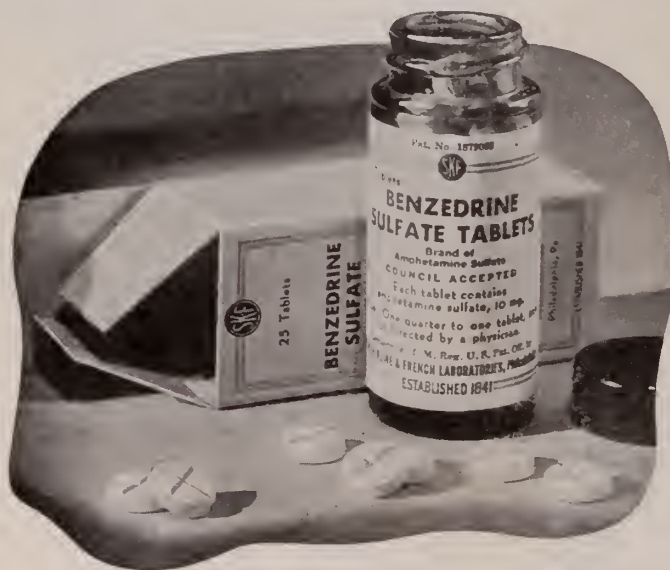


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FINKELMAN, I. AND SHAPIRO, L. B.: Benzedrine Sulfate and Atropine in Treatment of Chronic Encephalitis—*J. A. M. A.*, 109:344, July 31, 1937.

DAVIS, P. L. AND STEWART, W. B.: The Use of Benzedrine Sulfate in Postencephalitic Parkinsonism, *J. A. M. A.*, 110:1890, June 4, 1938.

MATTHEWS, ROBERT A.: Symptomatic Treatment of Chronic Encephalitis with Benzedrine Sulphate—*Am. J. Med. Sci.*, 195:448, April, 1938.

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\*Further Clinical Observations on Feeding Infants Whole Milk, Gelatinized Milk, and Acidified Milk. C. Loring Joslin, M.D., F.A.A.P.; Bulletin of the School of Medicine, University of Maryland; Jan. 1939.

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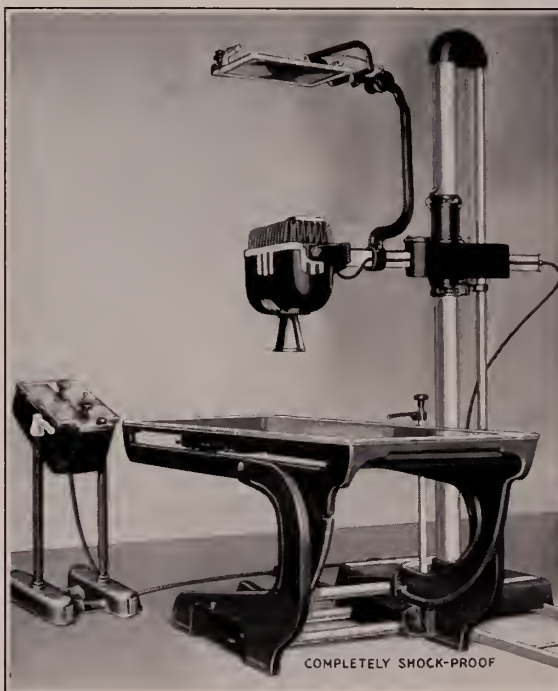
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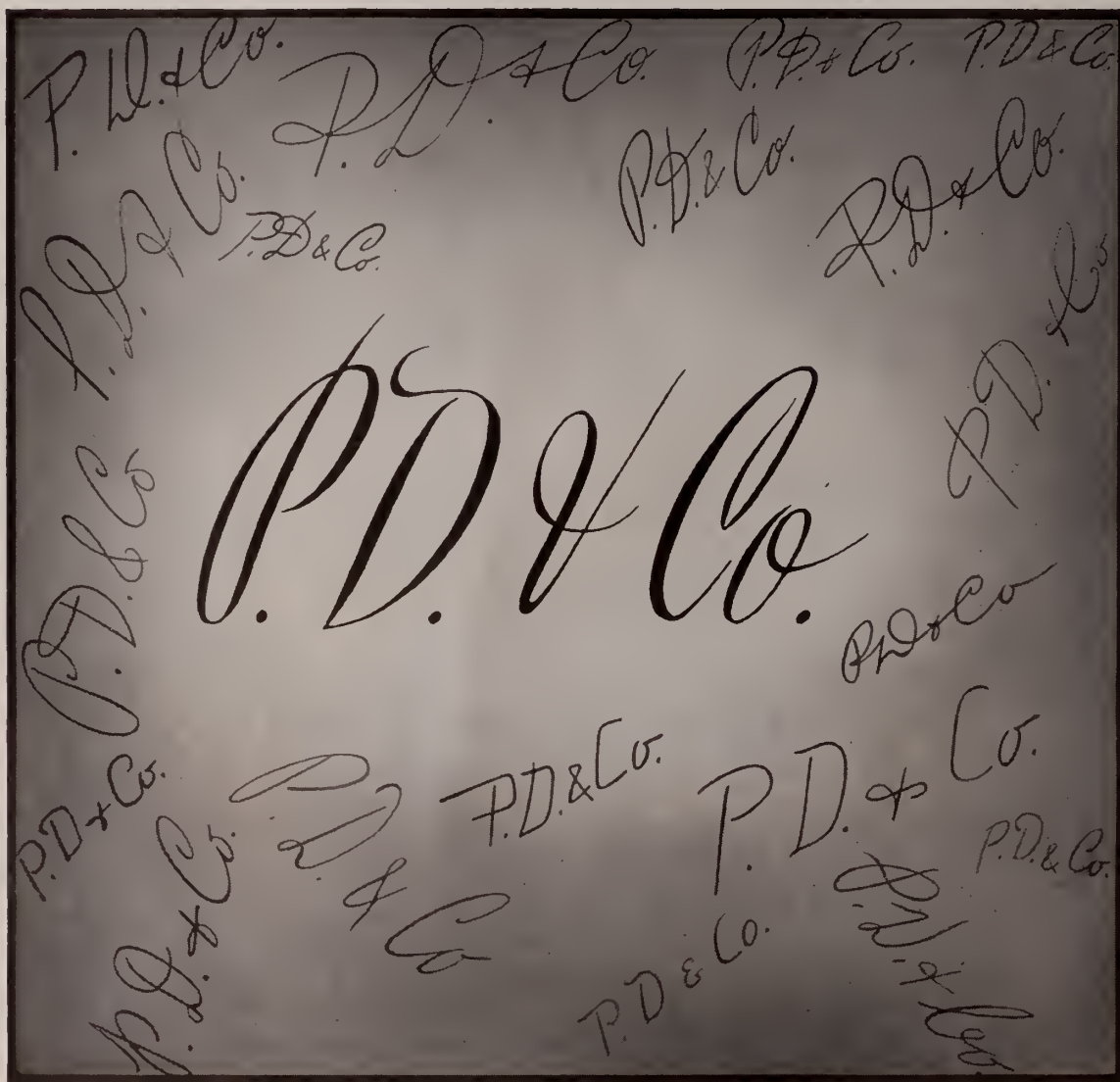
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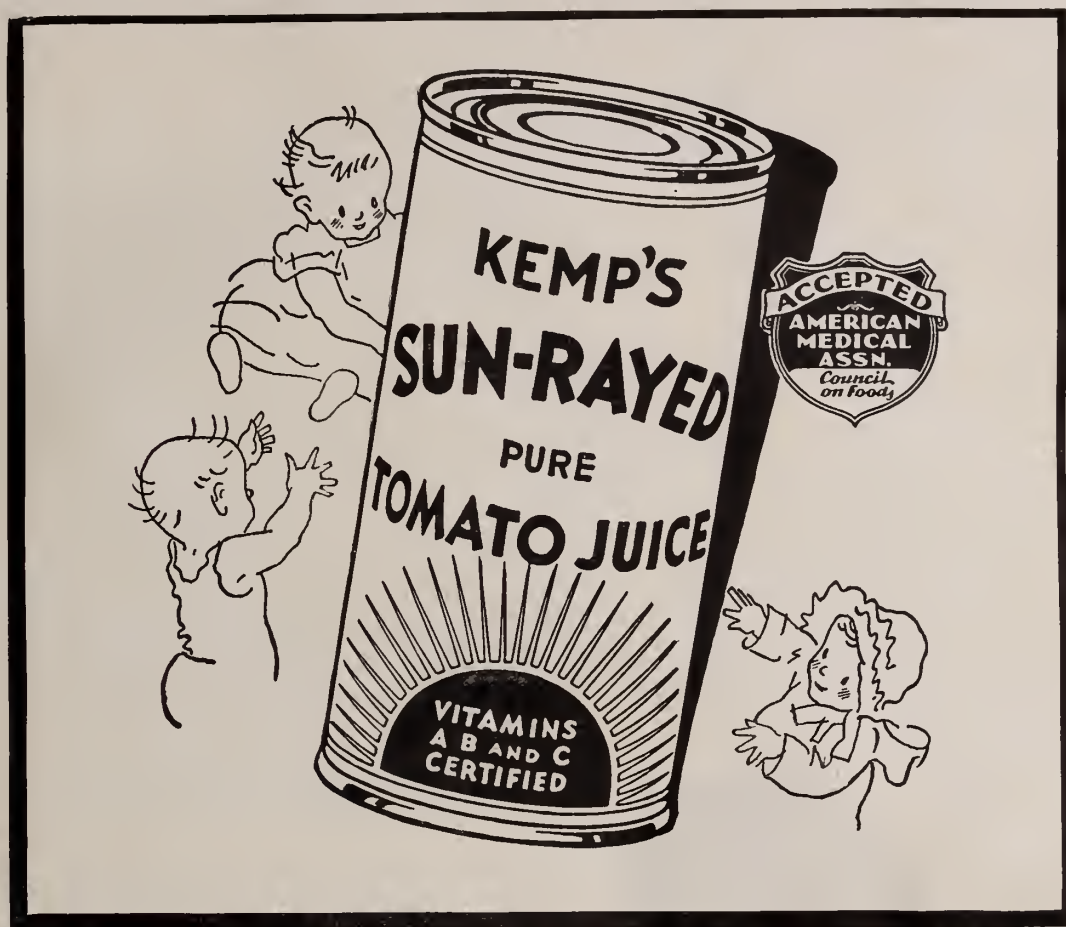
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# JOURNAL of The Connecticut State Medical Society

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APRIL, 1939

No. 4

## Surgery in Pulmonary Disease\*

EDWARD D. CHURCHILL, M.D.  
Boston, Mass.

For many years the anatomicopathological school of thought guided the development of abdominal surgery through the era of rapid technical advancement that followed the introduction of the principles of asepsis. Only recently has the center of emphasis shifted to what may be called the physiologic and biochemical approach. In the visceral surgery of the thorax the operative incision is a serious insult to cardio-respiratory function. No matter how erudite and well trained in anatomy and pathology, a surgeon faces disaster on opening the thorax unless physiologic principles are ingrained in his soul. The development of thoracic surgery awaited a generation of surgeons trained in physiology. For several years their first concern was applied respiratory physiology. The eclipse of anatomy and pathology was only partial, however, and of short duration, for old line anatomicopathologic problems are now foremost in the mind of the thoracic surgeon.

Thoracic surgeons are now writing the surgical anatomy of the chest, for items of immediate importance are not adequately covered in the classical texts. A surgical pathology of thoracic disease is being constructed from the "pathology of the living" giving a dynamic concept to disorders previously revealed only in the static terminal stages of the autopsy table.

The resection of a diseased organ or a portion of an organ is the most primitive and crude task of the surgeon, yet it is in this sphere that thoracic surgery has made its greatest advances in the past decade.

Resection of the lung may be carried out as a

removal of one entire lung (total pneumonectomy); the removal of one or more lobes of one or both lungs (lobectomy, unilateral or bilateral); the excision of a bronchovascular segment of one or more lobes (segmental pneumonectomy); or the resection en bloc of a portion of a lobe (partial lobectomy). The amazing reduction in the operative mortality rate of these operations has been the outstanding accomplishment of thoracic surgery during the past decade. The hazards of these operations are in no way unreasonable at the present time especially when weighed against the seriousness of the diseases for which they are undertaken.

In many clinics this type of surgery is almost routinely advised for primary tumors of the lung, benign or malignant; rare instances of metastatic malignant disease; bronchiectasis; cystic disease; lung abscess, usually after external drainage has demonstrated irreparable damage to the lung; and selected cases of pulmonary tuberculosis unsuited for collapse therapy usually because of stenosing lesions of the bronchi.

Statistics dealing with operative mortality are at the present time so colored by variations in the criteria of operability, as well as variations in the technics employed, that an estimate, if given conservatively, is of more significance than a careful analysis of reported cases. The existence of infection in the lung prior to operation materially increases the hazards of operation, as do also the nature and virulence of the infecting organisms. No analysis of results has as yet been offered on this basis. Total removal of the right lung will probably

\*Read at the 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.

always prove more hazardous than a left pneumonectomy. These figures are not available. Preoperative functional tests of the lung that is to remain are either not available to the operator or at the best exceedingly crude.

As a conservative estimate, however, it may be stated that the hospital mortality for total pneumonectomy in the absence of a pre-operative element of infection is leveling off at about 20 per cent; with infection, between 35 and 50 per cent. The hospital mortality for lobectomy in bronchiectasis with careful preoperative preparation and present day technics should not exceed 5 per cent in an unselected series of patients. In chronic lung abscess with persisting anaerobic infection, the hazard is somewhat greater, but probably not over 10 per cent. In other conditions, including pulmonary tuberculosis, experience is still too fragmentary to be significant.

Statistical evidence regarding the frequency with which the surgeon is able to arrest carcinoma of the lung will not be available for many years. Certainly there is no reason for the belief that surgery will be more or less efficacious in dealing with pulmonary carcinoma than it has been with, let us say, carcinoma of the stomach. The greater number of bronchogenic carcinomas of the lung are so situated anatomically that a total pneumonectomy is required for their extirpation. This operation permits a more complete removal of the regional lymphatics than does lobectomy. As the favorable results in arresting carcinoma, once the regional nodes are grossly involved, fall off sharply even in an organ such as the breast where the axillary contents may be removed en bloc, one cannot be enthusiastic in recommending total pneumonectomy for this reason alone. Theoretically it is a more ideal operation than lobectomy, but in view of the higher immediate mortality rate it carries, it is the author's opinion that lobectomy still finds a place in dealing with peripheral carcinoma when the primary tumor and any grossly involved nodes may be removed by the more limited procedure. If the operative mortality and late morbidity rate following the two operations could be placed at the same figure, total pneumonectomy would be the procedure of choice.

Before a surgical program can be planned in a case of bronchiectasis it is essential to have

an adequate bronchogram for the visualization of the extent and distribution of the pathology. In only 20 per cent of a considerable series of cases was the disease confined to a single lobe. The lingula of the upper lobe has been found diseased enough to demand resection in over 80 per cent of cases with left lower lobe involvement. Pulmonary segments such as the middle lobe on the right and the lingula of the left upper lobe may be resected at the time the lower lobe is removed. If the process is bilateral — for example, left lower lobe, lingula of the left upper lobe and right middle lobe, — a program of bilateral resection may be intelligently planned. Certain instances recorded as postoperative progression of the disease can be interpreted only as failures to demonstrate pre-existing involvement by incomplete bronchograms.

With the perfection of surgical technic it is justifiable to extend the indications for pulmonary resection in bronchiectasis to so-called "milder" forms of the disease. No longer is the surgeon forced to limit his efforts to those patients who have become "social outcasts" because of a copious production of malodorous secretions. A careful appraisal of the physical and psychologic effects of cough, hemoptysis, fatigue, episodes of pneumonitis and other symptoms of bronchiectasis on the social and economic status of the patient is in order. Indications for operation are often found outside of the sputum cup, and long before the disease has left its indelible stamp on the personality and career of the individual.

Accurate visualization of the pathology and the possibility of intervention in less advanced phases of the disease offer a challenge to the surgeon to eradicate all foci and at the same time conserve normal areas of lung. The operation of lobectomy has been a concession to operative technics in that the anatomic fissures of the lung rather than the pathology define the segment for resection. Segmental pneumonectomy, that is resection of the diseased bronchial segments within a lobe is, when possible, a more rational procedure.

While certain bugaboos of lobectomy, such as persistent bronchial fistula and unsightly chest wall deformity, have been almost totally eliminated by modern technic, the suppurative complications of convalescence may still be



formidable on occasion. Control of these is of urgent importance as the next step in perfecting the operation.

The role of pulmonary resection in lung abscess is assuming increasing importance. The problem of lung abscess by no means ends with adequate drainage. In certain sites adequate drainage may be established with difficulty or not at all. There are instances in which primary lobectomy is the procedure of choice in abscess therapy. More often, however, drainage of the abscess is the first step after non-operative measures have been proven ineffective. If the sequestration of the lung has been limited in extent, healing may follow simple drainage, or a plastic operation will be all that is needed. When a large defect exists in the lung, resection may be essential to bring about healing. Recurring hemorrhages either before or subsequent to drainage may force radical measures.

It is a disappointment to the ambitions of the thoracic surgeon that pulmonary tuberculosis does not readily lend itself to extirpation. Fortunately for the patient, collapse therapy is an admirable substitute. Thoracoplasty may be ineffective or actually make the situation worse if a major bronchus is stenosed from tracheobronchial involvement. This type of case is now being subjected to the more radical operation of lobectomy or pneumonectomy. The predicted difficulty with chronic sinus formation has not been a feature of the few recorded cases.

The many details that determine success or failure in this most difficult division of thoracic surgery are still far from standardized and the author can only outline the principles he considers important. As far as anesthesia is concerned three major conditions must be met: anoxia is to be rigorously avoided; the respiratory passages are to be kept free of secretions; and the depth and duration of anesthesia is to be such as to permit accurate and precise surgery. Maintenance of full surgical anesthesia with ether-oxygen administered through an intra-tracheal tube in a closed system has satisfactorily met these requirements in our hands. The strong prejudice against the use of ether vapor in the presence of pulmonary infection, tuberculous or non-tuberculous, has not been supported by fact.

Total pneumonectomy may be carried out by individual ligation of the vessels and careful suture of the main bronchus unless an inflammatory barrier makes dissection within the mediastinum impossible. In the absence of gross contamination from an infected lung, the pleural cavity may be closed without drainage and healing secured by first intention. If the likelihood of contamination exists, drainage is employed in anticipation of an empyema and at a later date a paravertebral thoracoplasty performed to obliterate the apical portion of the pleural cavity. This is usually the procedure in lesions that are primarily suppurative, whereas primary healing will be achieved in many cases of neoplasm.

Resection by use of the tourniquet technic is the common practice both in total pneumonectomy and lobectomy when an inflammatory reaction makes individual ligation of the vessels impossible or hazardous. As cases of bronchiectasis are subjected to surgery at an earlier phase of the disease, individual ligation of the hilar structures becomes increasingly more possible in lobectomy. It is essential for segmental pneumonectomy.

Thoracic surgeons have been greatly concerned with an assay of the relative merits of one and two stage lobectomy in bronchiectasis. The problem does not arise if the pleural cavity has already been obliterated by infection. While both procedures have their advantages and disadvantages, the pendulum has swung toward a more general adoption of the one-stage operation. When this procedure is adopted energetic measures must immediately be instituted to secure a rapid and complete reexpansion of the remaining lobe or lobes on that side. An interval of at least six weeks should elapse between bronchography and one-stage lobectomy.

As operation in bronchiectasis is an elective procedure except in the face of life-endangering hemorrhages, considerable care may be devoted to building up the patient for what is to be a strenuous ordeal at the best. Postural drainage, bronchoscopic aspiration and dietary control are all important preoperative measures. As the winter months are punctuated by recurring episodes of respiratory tract infection, operations have been abandoned during this period.

# Anesthesia for Surgery in the Open Chest\*

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Boston, Mass.

A consideration of the hazards to be overcome in the difficult group of cases requiring surgery through the open chest should lead to the best choice of anesthetic agent and of anesthesia procedure. The chief hazards which the plan of anesthesia should be designed to overcome are: (a) obstructing secretions and blood in the airway; (b) troublesome reflexes including cough; and (c) anoxia and circulatory strain.

**Secretions** or foreign material in the airway not only obstruct, but when sprayed over the good lung tissue may cause pneumonitis. Secretions and blood must be controlled and they can be by (a) Thorough postural drainage before and *during* operation. The operation is carried out with the patient in the head-down position. (b) Aspiration of the bronchi, as indicated throughout the operation. This necessitates the use of an intratracheal tube which should be inserted as soon as possible after induction of anesthesia. Cocainization of the pharynx is unnecessary for this procedure and adds to the hazards. At certain periods during open chest operations, routine aspiration through the intratracheal tube should be carried out whether or not secretions can be heard in the airway: notably, when the patient is turned on his side following induction and intubation, just after the pleura is opened, when the diseased lung tissue is mobilized, when the tourniquet about the lung stump is released, and at the end of operation before removal of the intratracheal tube. (c) Finally, the liberal use of atropine in gr. 1/100 to gr. 1/75 doses given subcutaneously will help minimize the formation of troublesome secretions in the airway.

**Troublesome Reflexes.** Cough is normally initiated by local irritation in the air passages. The reflex can be set up by surgical irritation of the afferent vagal fibers in the pleura. Efficient cough requires a closed glottis and intact chest wall so that intrathoracic pressure may

be built up. Efficient cough is impossible during open chest operations, not only because of the impossibility of building up a relatively high positive pressure, but also because of the unfavorable position of the patient during this type of surgery. It has long been recognized that cough has a spreading action as well as expulsive action. When an individual attempts to cough with an open chest he produces a sudden herniation of the lung through the orifice; coincident with this there may be a spread throughout all parts of the lung of infectious or irritating material that may be in the airway. Since cough has a spreading action it is of great importance to keep the airway free of infectious material. Cough during thoracic surgery dangerously increases the technical difficulties of the procedures undertaken. It is a mistake, I believe, to preserve the cough reflex in this group of cases. The anesthetist, not the patient, should assume the responsibility for maintaining free air passages.

Reflexes producing troublesome consequences are particularly likely to be set up by surgery at the hilum. Vagal stimulation occurs which leads to an irregular, jerky type of respiration interspersed with sudden periods of apnoea, and the heart rate is slowed.

These troublesome reflexes can be minimized by the use of atropin, since this drug frees the vagus. At times it will be necessary to inject procaine directly into the vagus as well as beneath the parietal pleura over an area about 15 cm. in diameter surrounding the pleura. Occasionally it will be necessary to eliminate the movements of the diaphragm on the side of the operation by injection of procaine directly into the phrenic nerve.

**Anoxia and Circulatory Strain.** The body's normal oxygen supply is hindered by (a) obstruction of the airway and by (b) the open pleura. The latter allows, as a result of the action of atmospheric pressure in the open

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chest and the respiratory movements, swinging of the mediastinum. Not only does this limit the aeration of the contralateral lung, but it gives rise to reflexes which probably are responsible for a fall in blood pressure. The open pleura interferes, then, not only with the intake of oxygen but with its distribution as well.

Several factors operate to reduce the circulating blood volume. In warm weather sweat loss is a factor. Pleural and mediastinal reflexes are important in the reduction of the volume of circulating blood. Also important are the circumstances which tend to produce shock, such as prolonged surgery and chilling. The heart is subject to great strain due both to direct pressure during the surgical manipulation and to anoxia. Generally this circulatory strain is latent and becomes apparent only if the patient is improperly handled at the end of the operation, as for example in careless, abrupt changes of position.

Anoxia produced as described above can be combatted in a number of ways. Atropin reduces the troublesome reflexes and diminishes the quantity of mucus and saliva formed. A closed anesthesia system and an intratracheal tube allows the administration of a constant high percentage of oxygen and the use of positive pressure anesthesia whenever it is needed to inflate collapsed portions of the lung, to restore or maintain a good blood color, or to aid in stabilizing the mediastinum. The head-down position promotes drainage; it minimizes the possibility of cerebral emboli; it aids in maintaining an abundant blood supply to the vital centers. Intravenous fluids, blood in particular, sustain the circulating blood volume notwithstanding the tendency to a decrease in it during surgery in the open chest. Blood transfusion also counteracts the copious postoperative weeping of the pleura with the consequent loss of in many cases 500 c.c. or more of blood plasma.

**Choice of an Anesthetic Agent.** The

choice is considerably limited by the exacting requirements of this group of cases, as outlined above. Ether seems to fit the requirements best, because of the high oxygen percentage one can use with it, the tolerance of the circulatory system for it, the low toxicity of the agent, and finally, its low mortality. The use of "avertin" for these cases is not desirable because of its depressant action on the respiration and circulation and its high mortality. Cyclopropane cannot be unreservedly accepted chiefly because of its to date inadequately evaluated toxic cardiac effects. Spinal anesthesia when used by a few intrepid surgeons violates all of the requirements outlined at the beginning of this paper and is not suitable for this group of cases.

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#### GIFT TO YALE UNIVERSITY

Yale University has received from The Rockefeller Foundation a grant-in-aid of \$189,000 toward the continued support of the Yale Laboratories of Primate Biology for the five-year period July 1, 1939, to June 30, 1944, and also the sum of \$35,000 for the construction of an additional laboratory building at the Anthropoid Station at Orange Park, Florida.

Under the reorganization of the Laboratories, following the ten-year period for which the project was originally financed, the Director, Dr. Robert M. Yerkes, will be responsible to an Administrative Committee, serving as a board of control. The following have been appointed members of this Committee: Doctors Carl G. Hartman, Research Associate in Embryology, Carnegie Institution, Johns Hopkins School of Medicine, Chairman; Edgar Allen, Professor of Anatomy, Yale School of Medicine; Leonard Carmichael, President of Tufts College; William H. Taliaferro, Dean of the Division of Biological Sciences, University of Chicago; Robert M. Yerkes, Professor of Psychobiology, Yale School of Medicine, Secretary; and, as member ex-officio, Stanhope Bayne-Jones, Dean of the Yale School of Medicine.

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(SEE PAGE 2.)



## Indications for Collapse Therapy in Tuberculosis\*

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The indications for collapse therapy in pulmonary tuberculosis are varied, as are also the methods used. There are three main types of collapse which have been found effective in the treatment of the pulmonary form of the disease, the indications for them differing in the individual case. These operative procedures are (1) the phrenic nerve operation which may be a temporary or permanent affair involving either the section or evulsion of the phrenic nerve (2) pneumo-thorax, the collapse of the lung by the introduction of either air or nitrogen gas into the pleural cavity, and (3) thoracoplasty, the extrapleural removal of ribs on the affected side, collapse being attained by the falling in of the chest wall.

The indications for phrenic nerve operation may be briefly summarized as follows:

1. The desire to promote healing in the small pulmonary lesion, preferably apical, or upper lobe, which has not shown sufficient tendency to heal following a period of bed rest.

2. As a second choice in cases showing varying degrees of involvement in which pneumo-thorax treatment has not been possible.

3. In conjunction with pneumothorax treatment to aid healing of a tuberculous lesion of lesser degree in the contralateral lung. Whereas some years ago it was the procedure to do the permanent phrenic or phrenic exeresis routinely, more recently it has been found advisable to do a temporary phrenic with a subsequent repetition of the same or a later exeresis, if the procedure has been found effectual in clearing up the pathology.

The phrenic nerve operation has been suggested first because it is a simple though less effectual method of producing pulmonary collapse than the two to be suggested later. However, it serves a useful purpose and has proved helpful in the arrest of many cases of pulmonary tuberculosis. It should be remembered, however, that it has definite limitations and too much benefit should not be expected from it.

Pneumothorax is applicable to the more advanced case of pulmonary tuberculosis, especially if cavity formation exists and the patient has a sputum positive for tubercle bacilli. It should also be considered in the lesion which shows a tendency to progress, even though the sputum may be negative for tubercle bacilli and though cavity formation is not apparent in the X-ray examination. A bilateral involvement is not a contra-indication to this type of therapy, provided, of course, the amount of involvement in either lung is not too extensive. Very satisfactory results have been obtained in many cases undergoing bilateral pneumothorax with a vital capacity reduced to 1200cc. Most patients showing such a low vital capacity are not distressed by shortness of breath except on marked exertion. Unfortunately the pneumothorax treatment of pulmonary tuberculosis cannot be used in all cases in which it would seem to be suitable. Too frequently a pleurisy, with its subsequent organization and the development of fibrous bands, prevents the use of this desirable method. Too frequently also such adhesions seem to be most marked over the particular area of the lung which should be collapsed. In the last few years it has been possible to overcome this difficulty in a certain number of these adhesive cases. This has been done by the Jacobeous operation, or pneumonolysis, in which operation the surgeon, by means of the electro-cautery, severs the cord-like bands which have prevented proper collapse of the lung.

It is useless and unfair to continue pneumothorax treatment indefinitely in the case in which satisfactory collapse cannot be obtained. Eventually one may expect either the development of fluid or spontaneous pneumothorax or both. Better to discard earlier the pneumothorax and advise thoracoplasty.

The more radical operation for collapse of the lung, thoracoplasty, has found increasing popularity in the last ten years. Again, such

\*Presented at Symposium on Surgery in Pulmonary Disease, 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.

an operation has its limitations and the cases eligible for it must be selected with care. A number of years ago Dr. Edward Archibald of McGill University stated that the first qualification for an individual to undergo thoracoplasty must be that he be a good chronic. Obviously then, one must exclude such types of tuberculosis as the acute exudative and the individual with a tracheo-bronchial complication. The best results are usually obtained in chronic cases where the disease is confined to one lung. Industrial workers exposed to dusty atmosphere containing silica are prone to develop silicosis. This condition frequently leads to pulmonary tuberculosis. Those so affected are poor risks for thoracoplasty chiefly because of a diminished vital capacity. Neither should the operation be considered in patients whose tuberculosis is complicated by asthma or amyloid-cardiac or renal disease. In our experience, neither laryngeal nor intestinal tuberculosis is necessarily a contra-indication to the operation.

Though most thoracoplasties are of the complete type — all ribs on the affected side being removed — it has been found sufficient and satisfactory in a number of patients, whose lesion is confined to one lobe of a lung, preferably the upper, to do a partial thoracoplasty removing six or seven of the ribs.

The limited time prevents only a sketchy presentation of the indications and contra-indications for these several operations. To arrive at a fair conclusion it is essential that each case be studied individually.



### COMPULSORY HEALTH INSURANCE

In 1933 it was found in England that those who carried government health insurance lost an average of twelve and one-half days per worker compared with nine days before health insurance was available.

In Germany, where compulsory health insurance has had a much larger experience, the annual time lost for sickness has increased in fifty years from five days to twenty-eight days. In the United States the average for all non-relief classes, according to the new Public Health Survey, is 9.8 days. The time lost for those on relief, according to the same survey, is 16.3 days.

The survey shows that 70 per cent of all cases of illness among relief families were attended by a physician. The proportion among non-relief cases, the income classes, was 74 per cent. Surely, no one is justified in reasoning from these facts that doctors are neglecting the poor. The proportion of disabling cases hospitalized was 26.8 per cent in relief families and 23.9 per cent among non-relief families.

The relief cases received more hospitalization than the lowest income non-relief cases. The survey on hospital cases show the facts even more favorable to the under-privileged — relief families 62 per cent, non-relief 41½ per cent. . . . .

Government is not competent to take care of medical ills. This has been shown in Europe's political medical situations. While diphtheria increased in both Germany and England under state medicine in a ten year period, 1922-1933, the disease decreased in the United States by 65 per cent. Tuberculosis decreased in England with state medicine 28 per cent, while in the United States without state medicine it decreased 48 per cent. The Metropolitan Life Insurance bulletin of January, 1938, shows a survey of 17,700,000 industrial policy holders. It shows new all-time lows for all causes of deaths; second, it shows an increase in the average life span to a new world's record; third, a death rate decrease of 36 per cent since 1911; fourth, the highest life expectancy in the world for the American child. Let me remind you that this was all accomplished under private practice and not under state medicine. . . . .

More people could pay their doctor if they placed their obligations ahead of their pleasures. The average American family pays more in gambling, extravagance, and laziness than they pay their family physician.—*Miller, Rocky Mt. Med Jour., Dec. 1938.*



### ANNUAL "RADIUM NUMBER" OF MISSISSIPPI VALLEY MEDICAL JOURNAL

The March issue is the Twelfth Annual "Radium Number" of the Mississippi Valley Medical Journal (Incorporating the Radiologic Review), published at Quincy, Illinois. This contains ten original articles, written especially for this issue, the most of which are contributed by well known American radiologists.



## Bronchoscopy\*

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On the program of this symposium are three questions relating to bronchoscopy. First, how does the bronchoscope help in the diagnosis and treatment of pulmonary disease? From the standpoint of diagnosis, a considerable portion of the respiratory tract can actually be visualized. The inside of the trachea, the region of the bifurcation, the main bronchi, the mouths of the upper and middle lobe bronchi can be directly inspected. The contour, color, size, microscopic pathologic changes and contents can be determined. Through the instrument secretions may be removed, the lungs palpated and biopsy specimens taken for microscopic study. Not only can we gain information by what is seen, but often diagnostic help is obtained by what can be felt with the bronchoscope. Mobility and fixation of the lung can furnish specific evidence of mediastinal disease outside the tracheo-bronchial lumen. Vital capacities of individual lungs can be determined with the apparatus of Frenckner.

The indications for diagnostic bronchoscopy are somewhat difficult to enumerate. In general, it is established that bronchoscopy is indicated whenever there is an unsettled pulmonary diagnostic question. The procedure cannot replace careful physical examination or the X-ray, but must be considered as an important adjunct to these. The following may be mentioned:

In bronchiectasis, secretions may be removed for bacteriologic study, much of the fetid odor can be eliminated and in differential diagnosis as to the particular lobes involved, the bronchoscope helps to locate the source of the secretions and aids in the injection of opaque media for roentgenography. Post-operative lung abscess cases should have the benefit of aspiration through the bronchoscope. Most of these follow an atelectasis and if the bronchoscope is

used before the suppurative stage has been established prompt relief is often obtained. Early bronchoscopy and aspiration in these cases is essential. Chronic pulmonary abscesses respond occasionally if removal of some secretion is all that is necessary to effect a cure. Asthma, especially in young people, has responded to various procedures through the bronchoscope, when other methods have utterly failed. Unexplained dyspnea, hemoptysis, cough or expectoration call for the more precise inspection of the lungs with the endoscopic instruments. Tuberculous ulceration of the trachea and bronchi overlying suppurating mediastinal lymph nodes can often keep a sputum positive. Localization of these spots often helps in the management of a case permitting the proper lateralization of collapse therapy.

Contra-indications to bronchoscopy hardly exist if the procedure is really needed. Aortic aneurysm, hypertension and advanced cardiac disease all render the procedure inadvisable. Acute infection makes postponement advisable. Hemoptysis is usually a contra-indication, although in the interim, between hemoptyses, the bronchoscope may locate the source of the hemorrhage.

Therapeutic measures through the bronchoscope are distinctly limited. The removal of foreign bodies, with which you are all familiar, will not be discussed here except to emphasize that in all cases of chronic suppuration a foreign body may be an important etiologic factor. The aspiration of secretions too thick to be expelled by coughing is often a very real benefit. When we consider the manner in which secretions are expelled from the lung, we can see how the bronchoscope helps. In lungs which are badly damaged, it is difficult for the patient to get air below the pus to push it out. During expiration, pus is squeezed into the bronchi by

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a sponge-like action of the lung tissue. Upon inspiration the pus returns to the lower air passages. Now if the bronchoscope is in place and suction is applied when the secretions are in the bronchi before inspiration occurs, the secretion is removed before it is sucked back into the lung tissue. Thus, in this way, although the suction tube is not actually deep in the lung tissue, much can be removed with the help of the respiratory action of the lung. Removal of mucosal crusts in tuberculous ulceration of the airway and in children in streptococcal or influenzal tracheo-bronchitis has frequently proved to be a life saving procedure.

Anesthesia in bronchoscopy is a subject of much discussion. I have found that no general rule can be established for this, but that each individual case must be decided upon the conditions which prevail and upon the purpose of the bronchoscopy. We are well aware of the individual variations to surgical procedures in different patients, and I consider very definitely that each case must determine for itself the type of anesthesia which is to be used. We have often found avertin very satisfactory because the cough reflex is often maintained while the patient is completely unconscious.

In the treatment of pulmonary disease, the bronchoscope often adds much to the proper regime of management. It is true that conservative therapy is not curative in advanced cases, but if the patient can be better prepared for surgical procedures, treatment through the bronchoscope must be considered as an important pre-operative measure. While suppuration may not cease following bronchoscopic aspiration, the secretions may be greatly reduced and much of the airway may actually heal when not bathed in the foul discharge. Even irrigations of the bronchi may be performed. Many patients who cannot be actually cured, can be so improved that they can carry on with repeated bronchoscopic aspirations. At the time of thoracic operation, important information can be frequently gained which will be of help to the surgeon.

More specific and precise treatments, including cautery of the bronchial wall, implantation of radium preparations, removal of benign

growths, are all being improved and will gradually be added to the therapeutic procedures.

The second question on this symposium asks if there are hazards associated with the use of the bronchoscope. The answer to this is obviously in the affirmative. Injudicious pressure to force the bronchoscope through the larynx may result in edema and obstruction to the airway. This is easily relieved, however, with tracheotomy. If an aneurysm is about to rupture into the trachea or bronchi, pressure from the instrument may hasten that event. Anomalous blood vessels in the bronchial wall around a suspected lesion may be damaged if biopsy is attempted. We have had such a case. The danger from visual inspection of the airway through the instrument is extremely slight, but as more and more manipulation and additional procedures are attempted, the hazards will correspondingly increase.

As for limitations implied in the third question, the actual part of the respiratory tract which can be seen with the present instruments is confined to the larger air tubes. But this by no means limits the inductive information which can be obtained. The actual limits are those which fall within the experience and ingenuity of the operator at the outer end of the instrument. Many of the technical difficulties have been surmounted by the development of a method, which actually places the instrument in the position without great difficulty. The various types of present day instruments are very satisfactory, but the advance must now come from a correlation of the methods of the actual passing of the instruments and a precise and perfected knowledge of the anatomy, physiology and pathology of the thoracic organs in health and disease. In this most bronchoscopists are deficient because their essential interest lies in the upper respiratory tract. The thoracic surgeon, however, is constantly concerned with the chest and from him will come the added benefits of the bronchoscope. As the urologist is a cystoscopist, the neurosurgeon a neurologist and the cardiologist a master with the stethoscope, so the thoracic surgeons will be the important contributors to bronchoscopy in the future.

## Diagnosis of Cavitation\*

WILLARD B. SOPER, M.D.

New Haven, Conn.

Diagnosis of cavitation of the lung has become increasingly important, particularly in pulmonary tuberculosis in which disease it is so often a determining factor in the decision as to collapse therapy. In other lung conditions too, it is important in both diagnosis and therapy.

The development of the conventional X-ray films marked a long step in advance. Focusing upon the suspected area with the Bucky diaphragm, simple over-exposure of the special area and various angulations were further steps in advance. The most recent X-ray development is the laminagraph, which permits of focusing the X-ray at different planes in any lung diameter and thereby obtaining a relatively clear image of a selected area through the elimination, to a large extent, of the ordinarily superposed shadows.

Laboratory methods may be of distinct help.

Although a high polynucleosis indicates a pneumonic or a necrotizing process in known tuberculosis, it goes no further than to confirm an impression of cavity obtained by other methods. For a long period the search for elastic tissue in the sputum was given up. With improved methods for its detection the search for elastic tissue becomes increasingly important. Finally, the presence of caseous material in the sputum and the presence of very large numbers of tubercle bacilli strongly suggest cavitation.

All of these methods combined, when used to check upon physical signs, show that the latter are not reliable for finding cavities of small size or those centrally located. Approximately only 30% of small and medium-sized cavities are diagnosable by physical signs alone, whereas the other methods will disclose the great majority.



### A PLAN FOR SAFE GUARDING THE PATIENT AGAINST UNNECESSARY SURGERY

Dr. J. J. Golub, Director of the Hospital for Joint Diseases, New York City, is the originator of a plan recently published in "Hospitals", in which a regional consultation service is set up as a safeguard to the patient against unnecessary surgery. The plan as outlined is a very elaborate one, comprising an executive director, an executive committee, a central consultation board, laboratories, regional consultation boards, each of the latter made up of two physicians.

The qualifications of the consultants are naive. "The consultants need by no means be chosen from among the outstanding members of the medical profession \* \* \* The primary purpose of

this plan is to bring within reach of patients the benefits of the professional opinion of three practitioners". The cost of operating such a plan in a city the size of New York would be \$2,012,-200 for one year. The necessary funds might be raised through taxation or by fees. The service could be a voluntary agency, not for profit, or under government control.

It is difficult to visualize the establishment and operation of such an intricate structure as outlined in this plan. It is also difficult to see just how it is going to curb the unethical or control the impetuous, hasty surgeon unless it is made compulsory.

One hesitates to believe that all the United States is in such dire need of reform as this plan would seem to imply.

\*Presented at Symposium on Surgery in Pulmonary Disease, 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.



## Treatment of Pruritus Ani\*

EDWARD H. KIRSCHBAUM, M.D.  
Waterbury, Conn.

Pruritus Ani, one of man's commonest afflictions, and occurring in a ratio of three males to one female, is seldom considered of any consequential importance by the average physician. Its assaults upon the comfort, rest and sleep, and thereby even life itself should be stimulus enough to institute a diligent search for a cure.

The causes of the disease are numerous, but unfortunately it is only the unusual case that is cured by the elimination of the etiological factor.

The symptoms need no description for the name of the entity is comprehensive enough.

The pathology consists chiefly of a lichenification and chronic inflammation of the dermis with a peculiar and striking absence of bacterial invasion.

The treatment is systemic and local. The first requisite is a complete physical examination including as it should a carefully done proctoscopy. Any pathology seen must be carefully noted.

Infection in the form of abscess or fistula should be cleared up first.

The next step is the local treatment and since, as noted above, the elimination of the probable causative condition will not as a rule result in relief or cure, the search for these and if possible their elimination should only be undertaken during or after the convalescence from the necessary local measures.

Absolute cleanliness is the first requisite. The use of lotions, cleansers and ointments will, like X-Ray, Violet Rays, Radium, etc., be palliative at best. Measures directed at the destruction of the irritated nerve endings have given the best results. These are operative and by the injection of various neuratropic solutions.

The operative procedures have not been so satisfactory as might be expected, for infection has been a frequent complication and recurrence quite frequent. Of these the operations of Ball, Lynch, Minor and Hertzler are most popular.

Injection may be expected to produce a cure in from 30% to 90% and this is dependent upon the solution used. These solutions are many and chief among them are 1-3000 Hydrochloric Acid, Benacol, Anucain, Anesthesin and Benzyl- Alcohol, Nupercaine, Quinine and Urea Hydrochloride, Distilled Water, Nutrient Broth, Histamine Hydrochloride and Grain Alcohol of various percentages.

Since the best results have been obtained with alcohol, I shall describe this treatment in more detail. There is an ambulatory method devised by Haskell & Smith and that requiring hospitalization advocated by Buie.

The area to be treated is thoroughly cleansed and painted with a suitable antiseptic. If the ambulatory method is decided upon the pruritic area is divided into thirds or quarters and one of these segments blocked and infiltrated with 1% novocaine. After anesthesia takes place 70% alcohol is carefully distributed subcutaneously in a fan-shaped manner through a single puncture wound with a small calibre (22 gauge) needle of adequate length and a suitable syringe. Not more than 10 cc. of 70% alcohol should be used at one time. The Buie method consists of the administration of a general anesthetic or a sacral block and the injection of about 30 cc. of 40% grain alcohol into the entire area at one sitting and in the same manner described above. Care must be taken in both methods not to inject into a vessel and not to inject the mucosa because of the almost sure sloughing of that tissue and resultant stricture formation. In both methods the area injected is massaged lightly and thoroughly in order to distribute the solution evenly. Cold applications are then applied to limit oedema and reaction, followed shortly by hot fomentations to prevent as much death of tissue as is possible. In both methods some sloughing of the skin is to be expected, but this

*(Continued on Page 173)*

\*Read before the 14th Clinical Congress Connecticut State Medical Society, New Haven, September 20-22, 1938.



## Brenner Tumors

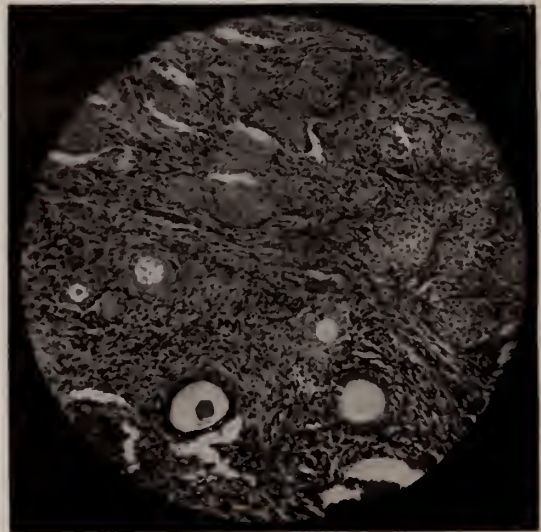
LOFTUS L. WALTON, M.D.\*  
Hartford, Conn.

In 1937 at the Hartford Hospital we made a study of the malignant ovarian tumors removed over a 17 year period. The classification of Meigs was followed and 97 neoplasms were subdivided as follows:

1—Papillary Cystadenomas	66	
a—Serous type		24
b—Pseudomucinous type		17
c—Unclassified type		25
2—Solid Carcinomas	14	
3—Embryonal group	17	
a—Granulosa cell type		10
b—Dysgerminomas		3
c—Arrhenoblastomas		2
d—Teratomas		2

No Brenner tumors were found, but since that time two of these interesting growths have been removed and studied. The benign ovarian tumors have recently been reviewed, lest a tumor of the Brenner type be hidden there; none such were found.

In 1899 Orthmann described what is at present thought to be a Brenner tumor. He gave it the name of "Fibroma Papillare Superficiale Carcinomatosum Ovarii". In 1907 Fritz Brenner published a report of 3 unusual ovarian tumors, two found at autopsy and one removed at operation. They were hard nodular growths, which microscopically revealed a large amount of fibrous tissue interspersed with alveoli and strands of epithelial cells. Some of these latter were arranged so as to suggest graafian follicles, hence Brenner incorrectly called his tumor "Oophoroma Folliculare". It remained for Robert Meyer to separate the Brenner tumor from the granulosa cell type. In the German literature there are less than 75 authenticated cases reported, whereas the case reports in this country total nearer 15. Von Szathmary in an experience of 15 years at the University of Budapest examined 1,114 ovarian tumors, 5 of which were Brenner in type. It has been



Case 1 — Fig. 1

Low power — Islands of epithelial cells scattered in cellular fibrous stroma. Note clear spaces in some and debris in others. Suggestion of graafian follicle.

said granulosa cell tumors occur eight times as frequently as the tumor being discussed.

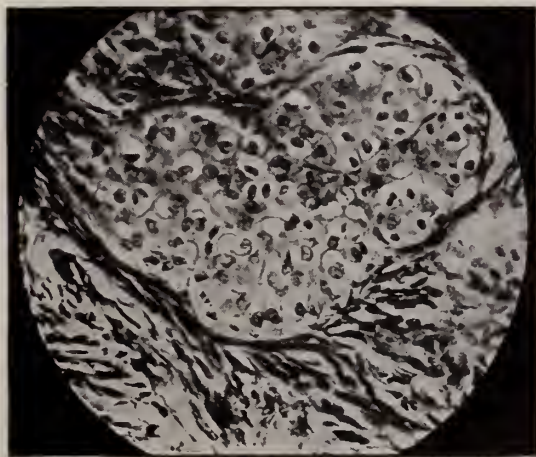
These fibro-epithelial growths occur in late life, fifty per cent after the half century mark. They do not give rise to post menopausal bleeding as the granulosa type, there being no hormonal stimulation. They vary in size from several mms. in diameter to 25 cms. Several cases have been reported as bilateral. Brenner tumors have been accompanied by a fibroma, a granulosa cell or an adenocarcinoma of the opposite ovary. The tumor in question is very hard and the diagnosis of fibroid uterus has been made a number of times. Calcification is more frequent than in ovarian fibromas. The fibrous tissue resembles ovarian stroma. The cords or islands as they appear on cross section, consist of epithelial cells that are polygonal in shape, have distinct nuclei and clear cytoplasm. Some areas resemble epithelial pearls. Brenner tumors are benign, Tavildaroff's case being the

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only exception. The name Fibro-epithelioma Mucinosum Benignum has been suggested to point out its harmless character. Cases have been followed for 12 years with no recurrences.

Following are two case reports:

1. Mrs. M.T., aged 58. Para II, menopause 8 years previously and chief complaints of low abdominal pain and frequency. Previous operations: Suspension, Appendectomy and Pelvic Repair. Physical examination revealed a well nourished, somewhat obese woman. Heart and lungs negative. B.P. 164/88. Abdomen negative except for right rectus and midline scars. Pelvic examination revealed the uterus anteverted and pushed a little to the right by a hard tumor of the right ovary. Operation: A Pfannenstiel incision was made and a very hard, well encapsulated tumor of the right ovary was removed. No free peritoneal fluid. The uterus was normal, left ovary atrophic. Her convalescence was uneventful. Pathological report — Macroscopic examination: Specimen consists of ovary and adjoining tube. The former measures 7x6x5 cms. The normal ovarian tissue is completely replaced by a well encapsulated tumor, which on cut section shows whorls of dense white tissue and at one end tissue somewhat softer and slightly yellowish in color. Tube shows no abnormalities. Microscopic examination: Bulk of the tumor is made up of interlacing strands of proliferating ovarian stroma. In one or two areas it is myxomatous in appearance. Throughout this proliferated fibrous tissue there are small solid alveoli made up of cells that are irregularly polygonal in shape and approach squamous cells in type. In a few of these there is a central space that occasionally contains mucus like material. Cells are fairly uniform in staining reaction and show only a few mitoses.



Case 1 — Fig. 2

High power. Typical cells. Polygonal in shape, nuclei well defined and cytoplasm clear. Note rows of fibrous tissue cells contiguous with epithelial islands.

2. Miss R.H., age 69, menopause 29 years previously. She has always enjoyed good health until four years ago, at

which time she began to notice a swelling of the lower abdomen. For the past year there had been frequency of voiding and for six months discomfort in the RLQ. Physical examination presented a somewhat thin woman of 69 years. The heart was enlarged to the left, A2 snapping and accentuated. B.P. 210/100. Vessel walls thickened. On abdominal examination a stony hard nodular tumor was felt, which extended 5 cms. above the umbilicus. Vaginal examination was impossible, outlet being virginal, externally the tissues showed the usual atrophic changes. By rectal examination the mass was well out of the pelvis. Pre-operative Diagnosis: Fibroid uterus. Operation: An incision from above the umbilicus to the symphysis was made. A large nodular tumor was delivered and found to come from the left ovary. Left tube and ovary were removed along with the tumor. Right adnexa was normal, and the uterus contained a minute fibroid on its anterior surface. Recovery was good.

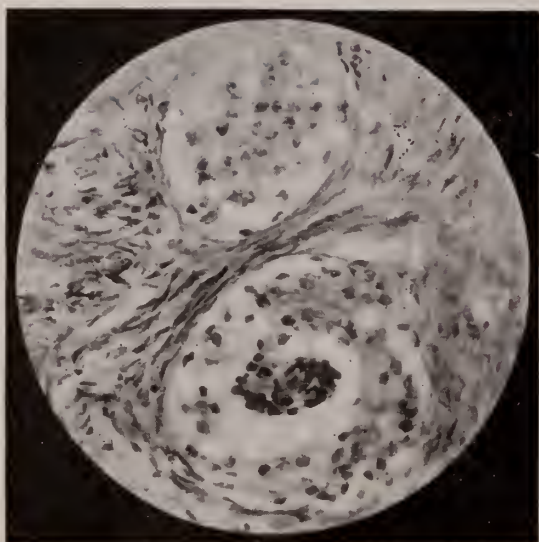


Case 2 — Fig. 1

On section there are many large yellow areas separated by trabeculae of white fibrous tissue. Note small cysts.

Pathological report. Macroscopic examination: An enormous firm, nodular, encapsulated tumor which measures 25x15x12 cms. and weighs 2230 grams. Attached to one side is a normal tube. Cut section of this growth shows a thin capsule, inside of which are numerous large islands of firm glistening, slightly yellowish tissue. In one or two areas there are several cysts which tend to be confluent, having a thin wall, a smooth rather trabeculated lining, on the surface of which is some yellowish mucoid material. The tissue cuts with the greatest difficulty, and there is calcification in places. No normal ovarian tissue found. Microscopic examination: Greater portion of the tumor is made up of a moderately cellular fibrous tissue stroma rather widely separating the small solid islands of epithelial cells. These cells are oval or polygonal in shape,





Case 2 — Fig. 2

High power — Cross section of two columns of epithelial elements. Note fibrous stroma.

and in a few of these there is a central area of vacuolization. In others, at the central portion, the cells are somewhat larger and have an irregularly polygonal outline giving a "pseudoppearl" structure. There is no definite invasion. Several of the cysts are lined by multiple layers of oval or cuboidal cells that have the structure and staining reaction of these cells. The lining is thrown into irregular festoons of coarse papillae. Here again the cells are uniform in staining reaction. In a few areas the fibrous stroma shows hyaline changes and masses of amorphous calcium deposits are present.

In 1903 Walthard described cell inclusions of the cortex of the ovary, rests of sexually indifferent cells. It is from this origin that most workers trace Brenner tumors. The epithelium in the tumor is sometimes mucous secreting and small Brenner tumors have been found in pseudomucinous cystadenomas. The suggestion has been made that there is a common precursor of the large clear cells of the Brenner type and of the pseudomucinous cells. Gaines has written an interesting resume of the genesis and histology of these tumors. In the illuminating articles on ovarian tumors of recent years this type has received only moderate mention. In 1929 Fleming of Glasgow reported three cases of a very unusual tumor which are thought at present to fall in this group. Bland, Novak, and Neiman have presented us with interesting discussions of Brenner tumors.

NOTE: I wish to thank Dr. Edward R. Lampson and Dr. James R. Miller for permission to report these two

cases and Dr. R. E. Kendall for reviewing the pathological descriptions.

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## Acute Coronary Failure

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Acute coronary failure may be defined as a condition in the heart resulting from the sudden inability of one or both of the coronary arteries, or their branches, to do their normal work. As a result of narrowing, spasm, or thrombosis in the artery (whatever the cause) its lumen is shut off, partially or wholly, temporarily or permanently, causing a loss of blood to an area in the myocardium with resulting anoxemia. This may be followed by such symptoms as body shock, severe pain or dyspnoea; and such complications as congestive failure, cardiac aneurysm, ventricular fibrillation, heart block, or embolism. Whether or not the patient survives depends upon the state of his heart muscle and general circulation before the acute onset; and upon the extent of the involvement plus the presence or absence of complications.

C. S. Keefer and Wm. S. Resnik<sup>1</sup> studied a series of 399 cases of angina pectoris which came to autopsy. This series consisted of some cases of their own, the majority having been collected from the literature. The result of the study showed that coronary sclerosis was present in 381 of the 399 cases.

O. Klatz and W. Lloyd<sup>2</sup> in a study of the pathological findings in 26 cases of advanced coronary arterio-sclerosis and 18 cases of coronary occlusion found no significant difference between them.

We see, therefore, that the striking resemblance between angina pectoris and coronary thrombosis is not surprising. The similarity is based on like pathological processes. Levine<sup>3</sup> writes in part: "Finally, it has been found that patients with angina pectoris, who never had an acute major episode requiring them to go to bed, or that can be recognized clinically as coronary thrombosis, not infrequently have curves that are diagnostic of myocardial infarction. From this it follows that myocardial infarcts occur as a result of gradual narrowing of the coronary vessels without acute thrombosis, or

that some of the attacks of angina are, in fact, attacks of thrombosis. Both of these possibilities are supported by post-mortem experience." It is not unusual for a case of coronary thrombosis to be mistaken for one of angina pectoris and visa versa. But, if one should be diagnosed for the other, the physician has not done a bad job. He has fallen down diagnostically only if he diagnoses coronary artery disease when the condition is extra-cardiac angina; or if he diagnoses extra-cardiac angina when the real thing is present.

The most important question that confronts the physician and the only one that needs to be answered is this: Is the patient suffering from coronary artery disease and are his present symptoms due to acute coronary failure?

Much stress is being laid on the importance of the differential diagnosis between coronary thrombosis and angina pectoris. This has become mere habit and serves no useful purpose.

In the surgical field, it is extremely satisfying to be able, on occasion, to make a correct pre-operative diagnosis of mesenteric thrombosis or intestinal obstruction. Nevertheless, the diagnosis of acute surgical abdomen would do just as well in most cases.

The above statements make no case for careless and lazy procedures; rather, they point to the occasional questionable value of ultra-smart diagnosis.

So it is with the diagnosis of coronary thrombosis and angina pectoris. I shall attempt to show that a differentiation is not important and that a diagnosis of acute coronary failure is best made for the good management of the patient's condition. Moreover, it makes the process of diagnosis less confusing to the physician and improves the prognosis.

The following table is presented, not as an aid to differential diagnosis, the value of which is unimportant, but only as a basis for review and discussion:—

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	A Coronary Thrombosis	B Angina Pectoris
Age Incidence	Similar.	Similar.
Sex.	Similar.	Similar.
Occupation.	Similar.	Similar.
Exercise.	Pain not related to.	Pain directly related to.
Type of Pain.	Lasts longer. Recurring cycles of severe and diminished pain. May last for minutes or hours.	Lasts for a few minutes. Rest and nitroglycerine bring relief.
Patients reaction to pain	Restless; May thrash around in bed.	Usually quiet; Apprehensive until pain disappears.
Location and distribution.	Similar.	Similar.
Nausea and vomiting.	Usually present.	Usually absent.
Relief from discomfort.	With morphine and not with nitroglycerine.	With rest and nitroglycerine.
Shock.	Usually marked.	Usually unrecognizable.
Perspiration.	Usually marked.	Usually absent or slight.
Facial color.	Ashen gray.	No definite change.
Blood pressure during attack.	Same as usual or falls.	Same as usual or rises.
Pulse.	May entirely disappear, become irregular, or remain the same.	Usually no change.
Heart sounds.	Weak or almost absent.	Weak or unchanged.
W. B. C.	Raised.	Normal.
Temperature.	Slightly raised.	Normal.
Sedimentation rate.	Increased.	Unchanged.
Over-eating, over-smoking, over-worry	Similar.	Similar.
EKG findings.	May be negative first day. Positive later.	May be negative even after years of attacks.
Prognosis.	Similar.	Similar.
Treatment.	Similar.	Similar.

A cursory review of columns A and B in the table leads to these conclusions: the chief points of difference in the two conditions lie in (1) Pain response, (2) Nausea and vomiting, (3) Relief of angina with nitroglycerine, (4) Shock, (5) Perspiration, (6) Facial color, (7) Blood pressure, (8) Pulse, W. B. C., Temperature and Sedimentation rate, (9) EKG findings. But despite this evident line of demarcation between angina and coronary thrombosis, one will frequently be diagnosed for the other because the above findings become interchangeable. Thus, (1) Pain may come on in coronary thrombosis immediately following exertion. Whereas, there are patients with angina who can walk around the house without discomfort, yet who will suffer pain after a few swallows of food. (2) Nausea and vomiting may be present after anginal attacks and absent in some cases of coronary thrombosis. (3) Some cases of angina are little relieved by nitroglycerine; only by rest. (4) Some thrombosis patients show no evidence whatever of body shock. (5) Some do not perspire, whereas some angina cases may do so profusely. (6) Facial color is also inter-

changeable. (7) The blood pressure does not always fall in coronary thrombosis and does not always rise in angina. (8) Pulse, Temperature, W. B. C. and Sedimentation rate findings are not always positive in coronary thrombosis. (9) Every physician who reads electrocardiograms has seen definite evidence of cardiac involvement in some angina patients. Yet there have been negative early readings following coronary thrombosis.

The last notation in each column under *treatment* is controversial. Very few men will agree with the statement that the treatment of angina pectoris and coronary thrombosis is the same. Yet, there is a small group, growing larger daily, who subscribe to the theory that enforced rest is not more unimportant in one than in the other.

Samuel A. Levine<sup>3</sup> writes in part, of angina pectoris: "When attacks are recurring very frequently and are quite severe, or when they actually prevent a person from attending to his work, it is wise to try a period of bed rest for several weeks. In some cases this alone improves the condition or at least renders free



from attacks or diminishes the frequency for a considerable period of time."

Paul D. White<sup>1</sup> writes, in part, of the treatment of angina pectoris: "If at the onset angina pectoris is unusually severe or frequent, or if in a milder form it does not yield in the course of a few days or weeks to various regulating measures of activity and diet, a trial of absolute rest in bed is astonishingly effective in a short time and the patient continues to be much improved for weeks or months after resuming a more or less active existence.

"Rest is always worth trying, at least before advising more radical surgical procedures. Whether absolute rest works chiefly by building up nervous energy and allowing recovery from fatigue, or by improving the coronary circulation, perhaps with the development of collateral vessels, or by cutting down the demands on the coronary circulation with the improvement in myocardial nutrition, or by a combination of these factors, we do not know."

It has been my experience that enforced bed rest has been an invaluable asset in the treatment of angina. Undeniably, the basis of all cardiac treatment is rest. This is the support on which drug and other therapy must lean before good results are possible. But bed rest should be ordered long before disability becomes pronounced. It should be prescribed immediately after the diagnosis has been made. The patients with angina who refuse bed treatment even for a short period of time, despite increasing attacks which are becoming more severe in nature, usually come to a sudden end soon after their increased disability. However, many patients at this stage, who have consented to periods of prolonged bed rest, have returned to restricted activity for years.

Studied in the light of the similar underlying pathology and the equally guarded prognosis in each condition, it follows that the immediate and interval treatment of angina pectoris and coronary thrombosis should be identical. If the patient is seen after only one or two attacks of angina, he should be put to bed and treated as if he were suffering from coronary thrombosis. If seen after giving a history of angina for months or years, the same procedure should be followed. Every patient will not be benefitted but many will be who otherwise would not be helped.

If experience with this method gives better results as regards the patients longevity, comfort or ability to be useful, then it must be conceded that a differential diagnosis between the syndromes under discussion is entirely unnecessary and that these are best grouped under the heading of acute coronary failure.

### Comment

The medical profession has been rightfully wary of accepting any new methods of diagnosis or treatment. Once having accepted a method, however, it is sometimes loath to part with it even though it becomes less useful. We have but to look back on how many patients dying of congestive failure due to hypertensive heart disease, were denied digitalis because of the teaching that digitalis was contraindicated in very high blood pressure. Many years passed before physicians lost their fear that the digitalis might rupture the heart of the hypertensive vessels in the brain.

Likewise, the differential diagnosis of angina pectoris and coronary thrombosis is relatively unimportant.

### Conclusions

1. The importance of the differential diagnosis between angina pectoris and coronary thrombosis has been over-emphasized.

2. These conditions might best be put in one category, acute coronary failure.

3. Pathological studies have proved that the underlying disease process in angina pectoris and coronary thrombosis is the same.

4. A table listing the comparative findings in the two conditions shows how easily interchangeable and confusing they may become in diagnosis.

5. The most important question that confronts the physician is this: Is the patient suffering acute coronary failure? (The etiology can safely remain unanswered for a few days.)

6. In view of the similar underlying pathology and the equally guarded prognosis in each condition, the immediate and interval treatment should be identical.

7. If it is agreed that enforced bed rest is equally important in each, then it must be admitted that the necessity for differential diagnosis between angina pectoris and coronary thrombosis has been unduly stressed.



# Sulfanilamide

## SULFANILAMIDE — WHAT IT IS AND HOW TO USE IT

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The action of sulfanilamide, the active portion of the dye prontosil, is largely bacteriostatic rather than bacteriocidal. Eventual recovery therefore depends on the phagocytic action of host cells. In patients who have responded to sulfanilamide treatment there is always danger of a relapse, if treatment is stopped too soon.

The drug is readily absorbed from the gastrointestinal tract and is rapidly distributed throughout the body. It may be recovered from blood, bile and all other body fluids. The optimum initial dose is about 0.05g per kilo body weight. The maximum concentration in the blood stream is attained in about 4 hours and since the level falls rapidly it is essential to treat the patient every four hours day and night. The drug may be administered by mouth or subcutaneously. A blood level of 7-10 mg % is needed. Sulfanilamide is eliminated by the kidneys and it is therefore essential to give relatively small doses in all cases with kidney damage. Small doses should also be given to patients with hepatic damage. The concentration of the drug rises more slowly in the spinal fluid. It is advisable to give an initial dose intraspinally when infections involve the meninges.

Sulfanilamide treatment has been found to be most effective against hemolytic streptococci, meningococci and gonococci. It is useful in certain infections by the colon bacillus and there are indications that it may prove efficacious in treating undulant fever. There is no evidence whatsoever that the drug is beneficial in cases of virus infection and since its administration is not without danger it should never be given to those with influenza, colds, etc.

Side reactions include nausea, cyanosis and possibly acidosis. It is advisable to give 15 gr. of sodium bicarbonate with each dose of sulfanilamide to counteract acidosis, if present. There is

always the possibility that the patient will develop an anemia, a leukopenia, a fever or a rash or some vascular injury that may lead to hemorrhage. Idiosyncracies such as these may be expected in about 15% of those treated.

—☆☆—

## SULFANILAMIDE IN PEDIATRICS\*

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The conclusions reported in this paper are based upon personal experiences at the New Haven Hospital. Sulfanilamide was found to be particularly effective in treating gonococcal ophthalmia neonatorum, erysipelas, and pneumonias and other infections caused by hemolytic streptococci. The cases of scarlet fever and of meningococcal meningitis which were treated were so mild that recovery could not be attributed to any specific action of the drug. No favorable results were obtained in cases of infection by *Streptococcus viridans*, *B. coli*, staphylococci or pneumococci. Sulfanilamide was not observed to have any benefits in the treatment of typhoid fever.

The dosage used at the New Haven Hospital is as follows:

For children under 6 months — 1.5-0.5 gr/lb

For children over 6 months — 1.25-0.25 gr/lb

For children over 6 years — 1.00-0.25 gr/lb

The optimum concentration of sulfanilamide in the blood is considered to be about 7 mg%.

Complications were numerous and sometimes serious. Those of minor importance included vomiting and diarrhea. No acidosis was noted. Skin reactions, fever and anemias were fairly common. The most serious complication was agranulocytosis which was encountered in two cases (1%). It would not seem advisable to use this drug except where and when it was possible to follow the concentration in the blood and to obtain white blood cell counts daily and red blood cell counts at least every two to three days.

\*Presented at 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22 1938.

FOR CORRECTIONS SEE

1939 V. 3 NO. 6 P. 274

also 1940 v. 4 no. 2 p. 73

## SULFANILAMIDE IN URINARY INFECTIONS

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Sulfanilamide is effective in the treatment of urinary infections caused by the gonococcus, B. coli, proteus and staphylococci. It is not effective against the tubercle bacillus.

The drug is tolerated poorly by old people, by those with high blood pressure and by all who are in a debilitated condition. The best results are obtained with children, and the next best with young adults.

Unpleasant reactions may be minimized by giving a small initial dose (about 20 grains) and by keeping the patients in bed. It has been noted that better results are obtained with patients who are in bed. Since patients react very differently to the drug at different times, the doctor should not be unduly discouraged if the first course of treatment is unsuccessful. Because of the dangers which attend the administration of sulfanilamide, all prescriptions should be unrefillable.

In about 10% of the cases treated the symptoms disappeared and the infections cleared up in a few days. In 40 to 50% the symptoms soon ceased but the organisms continued to be present. In the remaining cases no obvious benefit followed the administration of the drug.



## TREATMENT OF PRURITUS ANI

(Continued from Page 165)

is of no consequence as a rule, however the possibility had best be explained to the patient beforehand. When sloughs occur, they should be carefully trimmed away, (no anesthesia of course being required) and the wounds treated as any similar wound would ordinarily be treated. Only one thorough injection is necessary as a rule in the latter method, but weekly treatments are required in the ambulatory until the irritated nerve endings of all pruritic areas are destroyed. A total of four to six weeks treatment and observation is usually requisite. One may expect 85% to 93% cures by these two methods and only 3% require re-injection.

### Conclusions

I wish particularly to emphasize that there are many known causes of Pruritus Ani and the

elimination of these will not in many cases result in cure, but satisfactory relief can be obtained by methods designed to destroy the irritated skin nerve endings, the most successful of which is the careful subcutaneous infiltration of the pruritic areas with grain alcohol.

In a discussion of the treatment of this disease the time allotted is insufficient to permit a comprehensive dissertation and one must be content with the opportunity to instill a new or revive an old interest. Details are readily available in the literature.

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# Association of Connecticut Tumor Clinics

A Symposium Presented at the Eleventh Meeting of the  
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January 27, 1939

DRS. R. E. KENDALL, W. A. STANDISH AND D. J. ROBERTS

## OBSERVATIONS IN PATHOLOGY OF CANCER IN THE ORAL CAVITY AND LIP R. E. Kendall, M.D.

The gross statistics of the Tumor Clinic at the Hartford Hospital covering a five year period, 1932 to 1936 inclusive, show that 2015 cases of carcinoma have been registered. These cases have been followed at least two years. In the ward it has been possible to follow 99+ %, while in the private cases, followed through their personal physician, follow-up is less satisfactory.

In the Hartford Hospital Clinic cancer of the oral cavity and lip constitutes 6% of the total experience and in the following chart they have been grouped with the other "accessible"

### MALIGNANT NEOPLASMS, 1932-1936

2015 Cases			
G. I. Tract.....	29 %	Skin.....	6.7%
Stomach.....	9.3		
Colon.....	8.8	Mouth, Lip.....	6.0%
Rectum.....	3.6		
G. U. Tract.....	10.1%	Gyn.....	18.0%
Prostate.....	4.4	Cervix.....	9.8
Leuk, Hodg.....	4.9%		
Resp. Tract.....	4.4%	Breast.....	14.9%
Misc.....	6.0%		
	55.4%		44.6%

cancers. With our present methods of diagnosis and treatment it is worthwhile to focus attention on this group of carcinomas since they are available for early diagnosis and treatment and in them we should expect a high per cent of five year controls. It can be seen from the table that these accessible carcinomas constitute, in our experience 44.6% of the total number of cases and it is in this group that the most satisfactory results of education and therapy should be attained.

In a coarse pathological classification of tumors of the buccal cavity, including the lip, one sees from the second chart that the large majority of carcinomas are of the epidermoid

### MICROSCOPIC CLASSIFICATION

#### 200 Lesions

Precancerous (leukoplakia, etc.).....	22	
Epidermoid Carcinoma.....		83.4%
Grade I.....	58	
Grade II.....	66	
Grade III.....	22	
Basal cell.....	2	
Adenocarcinoma.....	17	9.7%
Lymphoblastoma.....	8	4.6%
Rare malignant tumors (sarcoma).....	2	

type, particularly if one includes with these precancerous lesions.

While the word "precancerous" is poorly chosen and may well be considered a misnomer, it still serves to convey the concept that the biopsy material under examination is sufficiently abnormal to warrant close observation of the lesion, additional biopsies and probably cancer therapy. It has frequently been pointed out that the margin of carcinoma is not distinct and often no sharp line between definitely malignant epithelium and normal epithelium can be drawn. There exists an "indeterminate zone" where cytological changes exist without evidence of invasion so that these lesions might be called "carcinoma in situ" or "surface carcinoma". Moreover, the multicentric origin of carcinoma of epidermoid type adds an increased difficulty in establishing the margin of the lesion.

The grading of the degree of malignancy has in this group of cancers been of slight prognostic value. The duration, size and extent of the

gross lesion and the presence of regional metastases are more important factors in the prognosis.

Basal cell carcinoma is strikingly absent in this material and in the two cases noted the lesions were at the vermilion border and might more truly be classified as skin tumors. This observation lends weight to the contention that basal cell carcinomas probably arise in hair follicles rather than from the surface epithelium.

Adenocarcinoma includes a bizarre group, probably derived from mucous glands or from heterotopic salivary tissue. They are unique in that their cytology does not give an indication of their invasiveness and ability to produce distant metastasis. Involvement of bone occurs at a surprisingly early stage in spite of the relatively slow growth of the primary tumor which together with the propensity to distant metastases makes them a very important group of mouth tumors.

Of the other malignant tumors of the buccal cavity little need be said. They are infrequent and represent curiosities rather than practical problems. The lymphoblastomas are in reality an intraoral manifestation of a more wide spread systemic malignant disease, while the rare sarcomas that have occurred in our group have been of muscle origin.

In summary it is noted:

1. That 44% of our total cancers are easily accessible for diagnosis and treatment.
2. That 90+% of intraoral tumors are epidermoid type.
3. That tumor grading is only a small factor in estimating prognosis.
4. That intraoral adenocarcinoma constitutes a small but important group.

### ANALYSIS CARCINOMA OF THE LIP HARTFORD HOSPITAL CASES 1930 - 1935

Welles A. Standish, M.D.

The group of cases of cancer of the lip presented herewith consists of 68 cases treated as in-patients or out-patients by the staff of the Hartford Hospital from 1930-1935 inclusive. This group includes all cases so treated except four which were not included as they had received treatment elsewhere, the character of which was not definitely known, prior to the

continuation of observation at the Hartford Hospital.

You will see, as the presentation proceeds, fourteen different treatments or combinations of treatments were used, tending to make any analysis and evaluation of the cases difficult. These groups have been combined into six classifications. The original intention, in preparing this analysis, had been to present the five year end results for the years 1930-1935 inclusive. However, when so many types of treatment and difficulties to be pointed out later were encountered, it was decided to present the analysis as follows. As you will see the groups consist of varying numbers of cases and certain factors will be brought out in all groups. No attempt will be made to present percentages.

#### RADIUM

- Number of cases — 30.
- Age — 35 to 83.
- Biopsy — 3.
- Size of lesion —  $\frac{1}{2}$  cm. to  $\frac{3}{4}$  lip.
- Duration of lesion — 1 mo. to 20 years (majority 2-6 mos.)
- Treatments — 24 received 1 treatment.  
6 received more than 1 treatment.
- Glands — 29 no glands.  
1 subsequent glands.
- Result — 18 living without disease (1 has had 2 subsequent ca. of lip).  
5 incomplete follow-up.  
1 died with metastases (subsequent) and lip lesion.  
6 died of other causes (2 with other malignancy).
- Follow-up — 2 yrs. 6 mos. to 7 yrs.

It is of interest to note, apropos of what Dr. Kendall has said that one case has had two subsequent cancers of the lip, occurring in entirely different locations and also that two cases died of other malignancies.

#### RADIUM

##### With X-ray to Glands

- Number of cases — 14.
- Age — 42-80.
- Biopsy — 7.
- Size — 1 cm. to entire lip.
- Duration of lesion — 6-12 mos.
- Treatments of lesion — 13 received 1 treatment.  
1 received 3 treatments.
- Glands — 6 no glands.  
6 initial glands (regressed).  
1 subsequent glands (dead).  
1 no glands — no follow-up.
- Result — 11 living without disease (1 sequestrectomy and plastic).  
2 incomplete follow-up.  
1 died with metastases (subsequent).
- Follow-up — 2 yrs. to 7 yrs. 3 mos.

There is nothing particular to point out ex-



cept to say that the amounts of treatment given varied considerably. There were no biopsies of the glands and prophylactic X-ray did not prevent subsequent metastases in one case.

### RADIUM and EXCISION

#### With or without Treatment of Glands

Number of cases — 9.  
 Age — 40 to 77.  
 Biopsy or op. specimen — 9.  
 Size of lesion — 1 cm. to entire lip.  
 Duration of lip lesion — 2 mos. to 2 yrs.  
 Glands — No glands — 4.  
     Of these — 3 received no treatment.  
                     1 received prophylactic X-ray.  
 Initial glands — 4.  
 Of these — 3 received neck dissection.  
     2 non-malignant — 1 malignant (dead).  
     1 received prophylactic X-ray.  
 Subsequent glands — 1 received neck dissection (dead).  
 Result — 7 living 1½ to 7 yrs.  
     2 died with metastases (13 mos. and 15 mos.)  
 Follow-up — 1½ to 7 yrs.

I would like to point out that the two cases with malignant glands in this series, died despite neck dissection.

### EXCISION

Number of cases — 8.  
 Age — 43 to 78.  
 Biopsy or op. specimen — 8.  
 Size of lesion — 1 to 2 cm.  
 Duration of lesion — 2 wks. to 12 mos.  
 Number of treatments — 5 — 1 excision.  
     3 — 2 excision (interval 5 mo.  
     10 mos. 4 yrs.)

Glands — 6 — No glands.  
     1 — Subsequent glands.  
     1 — Initial glands.  
 Result — 5 living without disease.  
     1 died of pneumonia — post-op.  
     1 died with metastases (subsequent).  
     1 No follow-up.

Follow-up — 2 yrs. 8 mos. to 5 yrs. 3 mos.

There was a relatively high number of re-excisions in this small group.

### EXCISION and NECK DISSECTION

Number of cases — 4.  
 Age — 39 - 68.  
 Biopsy or op. specimen — 4.  
 Size of lesion — 1 to 3 cm.  
 Duration of lip lesion — 2 wks. to 12 mos.  
 Glands — 1 initial glands (non-malignant).  
     3 subsequent glands (2 malignant - 1 non-malignant).  
 Result — 4 living without disease.  
 Follow-up — 1 yr. 9 mos. to 5 yrs. 10 mos.

	INITIAL						SUBSEQUENT					
	Radium	Rad.-Lip X — Neck	Excision	Exc.-Lip Neck Dis.	Rad. and Exc.-Lip C or S R Glands	Miscellaneous	Radium	Rad.-Lip X — Neck	Excision	Exc.-Lip Neck Dis.	Rad. and Exc.-Lip C or S R Glands	Miscellaneous
Non malignant Observation or Biopsy				1	2					1	1	
Regressions $\bar{c}$ Rx Nature unknown		5										
Regression $\bar{c}$ Rx Malignant										2		
Insufficient F. U.	5	2	2									
No glands	24	6	5		4	1						
No regression					1	1	1	1	1		1	1

This chart was made in an attempt to find if any type of treatment had any influence on the frequency of occurrence or the course of metastatic glands. As you will see the occurrence of metastases is pretty evenly distributed. The only living cases that had metastatic glands were treated by neck dissection.

In contra-distinction to the series shown on the third chart, the two cases with malignant glands in this group are still alive following neck dissection.

MISCELLANEOUS CASES

Number of cases — 3.  
Age — 52 - 53 - 70.  
Biopsy — 1.  
Size of lesion — 1 cm. to 3/4 lip.  
Duration of lesion — 2 mos. to 5 yrs.  
Case 1 — Lip — radium.  
Initial glands and jaw — radium, X-ray, resection of jaw.  
Result — Died post-op.  
Case 2 — Radium and X-ray — Lip.  
No glands.  
Result — Without disease 2 yrs. 3 mos.  
Case 3 — Lip — Radium and X-ray.  
Subsequent glands — Radium, X-ray, dissection.  
Result — Died with metastases.  
Follow-up — 7 mos. to 2 yrs.

SUMMARY

Number of cases — 1930-1935 inclusive — 68.  
Age — 75% between 50 to 80 — evenly distributed in the three ten year periods.  
Biopsy of lip — 12 cases } Grades i and ii.  
Op. Specimen — 20 cases }  
32 positive diagnoses of a possible 68.  
Size of lip lesion — 1/2 cm. to entire lip — average 2 cm.  
Duration of lesion — 2 wks. to 20 yrs.—average 6 mos.  
Result of treatment of lip — 66 healed.  
1 died post-op.  
1 not healed.  
Glands — 40 cases — no glands.  
6 cases — Regression of glands without treatment.  
2 cases — Regression of glands with treatment (No biopsy).  
2 cases — Regression of glands with treatment (non-malignant).  
2 cases — Regression of glands with treatment (malignant).  
9 cases — Incomplete follow-up.  
7 cases — Progression to death.  
End result — 45 cases without evidence of disease.  
9 incomplete follow-up.  
6 died without disease of other causes.  
2 died post-operative (one with metastases).  
6 died with metastatic glands.  
Follow-up — 1 1/2 to 7 years.  
No case recorded in the Tumor Clinic is without follow-up.

Conclusions

1. The relatively low percentage of the biopsies of the lip and glands is to be regretted, for it leaves some doubt as to the nature of the lesions and prevents evaluation of the treatment.  
2. Cancer of the lip responds well to all of the various types of treatment. The treatment

of choice should be that which evokes the least economic hardship, the least hazard and the least disfiguration.

3. The development of metastatic glands in this series has no relation to the type of treatment used for the primary lesion. Neck dissection in operable cases of metastatic glands does offer some hope of cure.  
4. It is noteworthy that the hospital cases, all of which are registered in the tumor clinic, have 100% follow-up. The cases with incomplete follow-up are private out-patients.  
5. It is most desirable that in the future the treatment of cancer of the lip, with or without metastases, be more consistent so that evaluation of the results will be more constructive than this series has been.  
In closing, I might add that most of the cancers of the lip treated subsequent to this group, have received low voltage X-ray locally.

INTRA-ORAL CARCINOMA  
ANALYSIS HARTFORD HOSPITAL  
EXPERIENCE  
Douglas J. Roberts, M.D.

Intra Oral Cancer while structurally like cancer of the lip differs from it, in that it is more apt to be neglected for a longer period — chiefly because it is usually located in the presence of a great deal of intra oral and dental sepsis and so is accepted by the patient as a chronic condition. Only when an enlarged node appears in the neck is the patient generally disturbed.

We have divided our main group rather arbitrarily for no sharp line of demarcation can be made unless dealing with an early small lesion. This is a rarity.

183 Cases					
	Less than		10 yrs.		Total
	3 yrs.	3 yrs. 5 yrs. or more			
(With disease)	96	4	3		103
Died					
(Without disease)	7	1	1		9
(With disease)	4	2			6
Lost to follow-up					
(Without disease)	10				
(With disease)	6	1	1		8
Living					
(Without disease)	23	3	18	3	47
CANCER OF TONGUE					
57 cases					
Dead of Cancer					33
Lost track of with disease (probably dead)					1
Alive with disease (1 1/2 years)					1



**Intermediate Group**

Dead of other causes & without recurrence (Two under 2 yrs., one 2½ yrs., and one after 7 years.)	4	
Lost track of without recurrence (after 1½ and 2 yrs.)	2	
Alive less than 5 yrs. without recurrence.	7	
	<hr/>	13
Alive after 5 yrs. without recurrence (5 to 12 yrs.)	9	
	<hr/>	57
Total 5 yr. cases treated (prior to 1934)	34	
5 yr. survivals	9	26%

Base of tongue tumors often first manifest themselves by cervical adenopathy.

A report of three year results on the forty cases of base of tongue tumors seen in two successive years at Memorial Hospital in New York was 0%

These are as a rule a highly undifferentiated and anaplastic group of tumors and as such are quite apt to be radiosensitive but are prone to early and extensive metastasis.

It has been stated that ⅓ of all patients with cancer of the tongue have syphilis. Our figures nearly reach this average.

**CANCER OF TONSIL**

Carcinoma	22
Reticulum Cell Sarcoma	3
Lymphoblastoma	4
Endothelioma	1
	<hr/>
	30

Dead of Cancer	24
Alive with disease (all less than 2 years)	3
	<hr/>
	27

**Indeterminate Group**

Alive less than 5 yrs. without recurrence (Two less than 2 yrs., one, 2½ yrs.)	3	
	<hr/>	3
Alive after 5 yrs. without recurrence	0	
	<hr/>	30
Total 5 yr. cases treated (prior to 1934)	12	
5 yr. Survivals	0	

Part of this series is really a local manifestation of a general disease.

This too is a group that is prone to appear first for treatment only when a node has enlarged in the neck.

Occasionally a tonsil is removed to clean up a supposed focus of infection under a diagnosis of a benign inflammatory condition and when a local recurrence appears a diagnosis of malignancy is suspected but usually nodes also are present by then.

**CANCER OF INSIDE OF CHEEK****31 Cases**

Dead of Cancer	17
Lost track of with disease (probably dead)	2
Alive with disease (4 yrs.)	1
	<hr/>
	20

**Indeterminate Group**

Dead of other causes & without recurrence (2½ years)	1
Alive less than 5 years without recurrence	6
	<hr/>
	7
Alive after 5 years without recurrence (Two 6 yrs. and one 7 yrs.)	4
	<hr/>
	31
Total five yr. cases treated (prior to 1934)	15
5 year survivals	4 26%

The most common finding in this disease is dental neglect. The common site for metastasis is the sub-maxillary nodes.

**CANCER OF FLOOR OF MOUTH INCLUDING GINGIVAL BORDERS AND PALATE****65 Cases**

Dead of Cancer	30
(Twenty-five under 2 yrs., one over 2 yrs., three between 4 and 6 yrs., one over 9 yrs.)	
Lost track of with disease (probably dead)	2
Alive with disease (two between 2 and 5 yrs., one for 6½ yrs.)	3
	<hr/>
Total failures in treatment	35

**Indeterminate Group**

Dead of other causes and without recurrence (Two under 2 yrs., one over 2 yrs., and one over 4 years)	4
Lost track of without recurrence (Six under 2 yrs., one over 2 yrs.)	8
Alive less than 5 yrs. without recurrence (Three under 2 yrs., six between 2 and 5 yrs., one 21 yrs., recurred 3 times, last 1½ yrs. ago)	10
	<hr/>
	22
Alive after 5 yrs. without recurrence (5 to 10 yrs.)	8
	<hr/>
	65
Total 5 yr. cases treated (prior to 1934)	37
5 yr. survivals	8 22%

The average length of time before appearing for treatment is 5½ months. Leucoplakia is the commonest finding in this group, and when fissured or ulcerated a biopsy should always be

taken. All of our long-lived group that ultimately died of the disease would recur, often many times, on a persistent leucoplactic base. It is in this group that the majority of the adenocarcinomas are found.

Adenocarcinoma of the Oral Cavity

Because of the variation in the microscopic picture the gross character and clinical course is important in making the diagnosis. The course is slow growing, painless and usually over a period of years but the tumor may suddenly grow rapidly. The tumors as a rule are derived from minor salivary glands but may arise from aberrant thyroid tissue or mucous glands.

The appearance is important — usually an oval or round mass, may be slightly lobulated, but is usually smooth, adherent, slightly thickened and with an intact overlying surface. Prominent capillaries are often seen on the surface. Ulcerations may occur, but if so, usually from pressure necrosis. The lesion may be found anywhere in the mouth but ordinarily on the hard or soft palate or at the base of the tongue. Biopsy is baffling, the appearance being less malignant than the clinical course warrants. The tumor feels firmly elastic and may suggest fluctuation but not liquifaction and is deeply fixed as a rule. The palate lesions are apt to be pale, shiny, reddish yellow, those at the base of the tongue of a deeper reddish, granular appearance. The encapsulated appearance is more apparent than real. There is a marked tendency to local recurrence, bone invasion and even remote matestases.

Surgical excision alone will cure these lesions if they are still encapsulated but this is difficult

to anticipate; so radon seed implantation followed by surgical, preferably cautery, excision seems the method of choice.

10 LIVING PATIENTS WITH COMPLETE DATA

Follow-up Period	No. of Cases	Without Loc. Rec.	With Loc. Rec.
From 1-5 yr.	1	1	0
From 5-10 yr.	6	4	2
From 10 yr. and up	3	0	3

This table shows that recurrences of this form of primary tumor are apt to occur five years or more after treatment, quite a reversal from the usual tumor statistics.

SUMMARY OF INTRA ORAL CANCER

A group of 183 cases has been analyzed.  
Total 5 year cases .....98  
Total 5 year controls .....21.5%  
Diagnosis based on biopsies .....84%  
Sex incidence — 1 Female to 6 Males

Hart. Hosp.	5 Year Results	Mem. Hosp., New York
22% Floor & Roof of Mouth		22% (naso-pharynx)
26% Tongue		26%
26% Cheek		30%
0% Tonsil		0%

Treatment in this group has been generally radiation for the primary lesion with surgery playing an important, though a secondary role, with, however, several exceptions chiefly in the tongue and the adenocarcinoma groups. The treatment of cervical metastasis has depended upon the nature and position of the primary growth as well as upon the status of the meta-static changes. Both surgery and radiation as well as a combination of the two have been utilized.

(Continued on Page 185)

Four typical cases of 17 total

Case No.	Date Onset	Location Primary	Treat. Primary	Metastasis	Treat. Rec.	Outcome	Duration
1 M.P.	1918	Soft Palate	Excis. Irrad.	1930 Cerv. Nodes 1937 Cerv. Nodes ea. side neck	Irrad.	Dis. free	1 ¼ yrs.
2. E. D.	1919	Hard Palate	Excis. (Extensive)	1923 Loc. Rec. 1930 Loc. Rec. 1934 Loc. Rec.	Irrad. Irrad. Irrad.	Dis. free	3 ¾ yrs.
3. M. S.	1920	Hard Palate	Excis.	1928 Loc. Rec.  1934 Loc. Rec.	Excis. & Irrad. Excis. & Irrad.	Dis. free	4 ½ yrs.
4. R. F.	1929	Hard Palate	Excis.	1930 Loc. Rec. Bone Met. Lung Met.	Irrad. Irrad.	Died after	1 yr.



# State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

## Biologics Distributed by the State Department of Health

LAURENCE A. FAGAN, Chief, Division of Supplies

Scientific research during recent years has made it possible to offer the medical profession biological products of greater concentration and more potency in less volume than heretofore. Such an advancement has been welcomed by both physicians and patients. Methods of concentration remove bodies that might cause reactions, increase the potency of the preparation and decrease the cost of packing. Not only does the individual benefit by reductions in manufacturing costs, but large buyers, such as state departments of health throughout the country, also benefit because they are enabled to buy more material with the limited funds available. Thus they can get more for the tax dollar with the result that the material can be distributed more widely so as to be more effective in the cure and prevention of diseases.

The distribution of therapeutic and preventive biologics is now recognized as a public health measure as their use is a means of safeguarding the health of the general public. Because the type of biological products placed on the market is in a dynamic state and is constantly undergoing change and modification, the state department of health keeps itself informed as to any alterations in the products, obtaining both laboratory and clinical data when necessary, and advocating or adopting a new material only after it has proved effective through adequate experience based on clinical application in statistically significant amounts. The state department of health is in a position to acquire the necessary data to know where satisfactory biological products may be obtained, and to keep them under proper refrigeration to preserve their effectiveness so that they may be properly and promptly distributed to

combat the particular diseases for which they are used.

The state health department maintains a twenty-four hour emergency service for supplying biologics when needed. The distribution of biologics by the department is governed by Section 2392 of the General Statutes, Revision of 1930, which reads as follows: "Said department is authorized to procure diphtheria antitoxin, tetanus antitoxin, vaccine lymph or other biologic products for the free use of the people of the state upon whom the purchase thereof would impose a financial hardship, and to distribute the same to town, city and borough health officers who shall furnish the same to such persons upon recommendation of attending physicians".

Connecticut began its distribution of biologics in 1911 with an appropriation of \$8,000. Since that time, with the development and perfection in the manufacture of various biological products, and the education of the public as to the desirability of using them, the demand for this service has increased tremendously. Although biologics cost considerably less per unit than they did in 1911, the state is now spending about \$45,000 annually for free biologics distributed throughout the state. Of this amount, \$25,000 is a state appropriation and the remainder is a grant from the U. S. Public Health Service. The material furnished by the state from July 1, 1937 to June 30, 1938 is as follows:

<i>List of Materials</i>	<i>Amount</i>	<i>Cost</i>
Antimeningococcic Serum, 30 cc.	554 pkgs.	\$ 2077.50
Antipneumococcic Serum, 20,000 units, Type I and II	2074 pkgs.	14414.30
Antipneumococcic Serum, 20,000 units, Type III	88 pkgs.	1320.00
Antipneumococcic Serum, 20,000 units, Type IV and VIII	501 pkgs.	4403.75

Antipneumococcic Serum, 20,000 units, Type V and VII	705 pkgs.	6168.75
Diphtheria Antitoxin, 1000 unit vial	1811 pkgs.	543.30
Diphtheria Antitoxin, 10,000 unit vial	1462 pkgs.	2924.00
Diphtheria Toxoid 2 vials (complete)	4810 pkgs.	2405.00
Diphtheria Toxoid, 30 cc. vials	2800 pkgs.	3136.00
Diphtheria Toxoid, dilute, 2 vials (2 cc. ea.)	120 pkgs.	74.40
Scarlet Fever Antitoxin, 6000 units	361 pkgs.	1805.00
Shick Test for 10 persons	1113 pkgs.	459.15
Shick Test for 50 persons	630 pkgs.	410.10
Smallpox Vaccine, 1 tube	4163 pkgs.	208.15
Smallpox Vaccine, 5 tube	2774 pkgs.	693.50
Smallpox Vaccine, 10 tube	2411 pkgs.	1205.50
Tetanus, 3000 unit vial	8043 pkgs.	9283.28
Tetanus, 10,000 unit vial	1014 pkgs.	2905.18
Typhoid Fever Vaccine, 3 vial, complete	1014 pkgs.	354.90
Typhoid Fever Vaccine, 20 cc. vials	363 pkgs.	344.85

The material purchased with federal funds is also available to physicians in accordance with the state statute mentioned heretofore. However, while serum is available for many of the thirty known types of pneumococcic pneumonia, the department furnishes only Types I and II, IV and VIII, V and VII, all bivalent, and Type III, monovalent. The limited funds available do not permit the distribution of other types of serum. In fact, funds are so limited that Type III may be discontinued.

The state department of health distributes all biologics through local health officers to physicians to be used by them in accordance with state statutes. In our larger cities, adequate supplies of biologics are maintained for those communities and such supplies are made available to physicians in nearby communities when required for emergency cases.

The distribution of biologics and their refrigeration constitutes a problem in itself. The manufacturers of the various products have always given the department their fullest co-

operation and assistance, and have always used *every* available means of transportation to assist in any emergency or epidemic. In the 1928 smallpox outbreak, one shipment of vaccine virus reached the department by special messenger within three hours after the order was placed. In another emergency, an express train was held up so that a supply of serum could be placed aboard. More recently, during the 1936 and 1938 flood emergencies, orders for biologics were given preferred attention to such an extent, that at no time during these hazardous days were we unable to meet the demands made upon us by health officials in the devastated areas. The department itself, makes every effort to see that shipments are made promptly and expeditiously to whatever point necessary, both day and night.

The department endeavors to purchase those products that are most essential for the general protection of the public, at prices determined by competitive bidding. It has been the policy of the department to spend such money carefully and wisely and where it will do the most good, realizing that such funds are obtained through taxation and that the public demands improved service and economy in government expenditures.



#### SYPHILIS AMONG THE NEGROES IN ALABAMA

Forty colored people, out of every 100,000 living in the State died as a direct result of contracting this disease in 1936. The ratio of syphilis deaths to population in that year was more than twice as high as that for the year 1914 and was higher than that for any previous year for which the State Department of Health has any records, with the single exception of 1928. Syphilis among Negroes thus constitutes one of Alabama's great unsolved problems and it is equally serious in other states having large Negro populations.—*Jour. Med. Assoc. Ala., Jan., 1939.*

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## Automobile Insurance

Automobile insurance is rapidly becoming a subject of vital interest to the physicians of Connecticut. The reasons are obvious. Connecticut at present has a motor vehicle financial responsibility law which requires the furnishing of evidence of financial responsibility as the result of convictions of violations of certain stated motor vehicle laws. As the law now reads the motor vehicle commissioner may pass judgment on each individual case involving a violation as distinguished from a conviction. There is no provision requiring evidence of financial responsibility upon failure to satisfy judgment.

Realizing that the present Financial Responsibility Act is not satisfactory, in 1936 Governor Wilbur L. Cross appointed a temporary commission to study the act. The commission consisted of John C. Blackall, Insurance Commissioner, Michael A. Connor, Commissioner of Motor Vehicles, and Frank P. McEvoy, Judge of Superior Court. In December of that year this commission presented its report to the effect that "the perfect objective would seem to be a fair, reasonable, workable law which would assure to every injured person reasonable compensation for injuries and expenses and require such payment by everyone responsible for such injury". The commission recommended the setting up of a State Fund from which the medical, surgical, hospital and nursing expenses would be paid for every resident of Connecticut injured by an automobile upon a public highway in the State of Connecticut in a sum not exceeding three hundred dollars. This fund was to be "administered expeditiously and without delay and, particularly, without any reference to whether there is a fault or ultimate recovery on the part of the injured person".

No bill was submitted at the time this report was made by the temporary commission but in the following month, January 1937, Senate Bill 800, "An Act Concerning the Creation of a State Fund for the Payment of Doctors, Hospital, Nurses and Medical Expenses for Services Rendered to Residents of the State of Connecticut injured by Automobiles" was submitted. This bill called for the additional pay-

ment of \$2.00 by every person applying for the registration of a motor vehicle, this additional \$2.00 to be paid into a fund known as the State Medical Reimbursement Fund. This bill also called for the administration and distribution of this fund by the Workmen's Compensation Commissioners of the State of Connecticut in the district in which the injury occurs in a sum not exceeding \$300 for injury to any one person by an automobile on any public highway in the State of Connecticut. Senate Bill 800 was defeated in the 1937 session of the General Assembly.

During the present session of the General Assembly the Governor appointed a committee to study the problem of automobile insurance. On this committee were represented the various interests most vitally affected by any plan of automobile insurance. The members of the former Temporary Commission appointed in 1936 were included in the committee and organized medicine was represented by the Executive Secretary of the Connecticut State Medical Society. Three plans of automobile insurance were discussed, viz., (1) a State Insurance Fund, (2) Compulsory Insurance, and (3) a strong Financial Responsibility Act.

1. A State Insurance Fund. The stock insurance companies writing insurance in Connecticut are opposed to this plan which was suggested in the report of the Temporary Commission of 1936 because they believe that it would permit the state to enter the insurance business and permit further control of individual business. Any insurance in a State Fund against loss on account of liability for bodily injuries resulting from the ownership of an automobile, without regard to the particular basis upon which such liability might be determined, is unpopular with the stock insurance companies. They cannot visualize any relationship existing such as the employer - employee one whereby the administration and distribution of such a fund could be cared for by the Workmen's Compensation Commissioners. They believe that imposition of liability without regard to fault would soon grow to provide indemnities for loss of earnings, specific payment for loss of life or limb and for permanent physical impair-

ments, considerations far beyond mere medical and surgical expenses. The representative of organized medicine on the Governor's Committee favors this plan and expresses the sentiment of organized medicine in Connecticut as being in the majority in favor of compulsory financial responsibility. The Executive Secretary of the Connecticut State Medical Society believes that attention should be directed to the problem of automobile insurance and favors carrying on the study made by the previous commission for the next two years. It is of interest to note that Louis H. Pink, Superintendent of Insurance in New York State, in his report just published, states that an automobile compensation plan, compensating all who suffer injuries growing out of automobile accidents regardless of fault, would be opposed by the legal profession since it would remove from the field of litigation the major source of business so far as the law of negligence is concerned. Private insurance enterprises would oppose such a plan, according to Mr. Pink, because it suggests the establishment of state insurance funds. The New York Insurance Superintendent is of the opinion that such a plan would necessitate legislation which would be unconstitutional. The absence of the employer - employee relationship in the automobile fields he believes would substitute a heterogeneous for a homogeneous benefit group delaying investigations, medical and surgical attention, and promoting opportunities for fraud and chicanery. This, of course, would defeat the entire purpose of the plan which is to secure prompt payment for medical and hospital bills without any reference to whether there is fault or ultimate recovery on the part of the injured person. Many believe such a plan would discriminate in favor of physicians and hospitals and as such would be a special benefit or group legislation and therefore should not be considered.

2. **Compulsory Insurance.** Only one state, Massachusetts, has passed a Compulsory Act. Whether or not it is successful in accomplishing that for which it was intended is still debatable. Litigation has been increased. If our legislature passes a similar act it must create legislation expanding the courts and their facilities. Some believe that compulsory insurance will increase the accident incidence. In-

surance carriers in Connecticut do not actually believe this to be true and at all events there is no proof of it one way or the other. The glaring fault with compulsory insurance is that it does not reach all automobiles traveling the highways. Many policies are cancelled for non-payment of premiums and in many instances the state has never been able to recover the license plates. There are always 5,000 or more uninsured automobiles on the highways of Massachusetts carrying license plates to which their owners are not entitled because of unpaid premiums. Compulsory insurance in private corporations compels a large majority of automobile owners to patronize insurance companies so that a small minority will be able to pay the damages they cause. Under this plan the rates will be determined by the state and will of necessity become a political football. There will be some who will be unable to obtain insurance, since a minimum of interference with insurance underwriters is to be desired, but if the insurance companies are compelled to insure everyone there will be many bad risks accepted.

3. **A Strong Financial Responsibility Act.** New Hampshire has such an act now in force, an improvement over the present Connecticut act. The private insurance enterprises favor amending the present New Hampshire law so that it will not be necessary to suspend the license or registration of a person who may be involved in an accident but whose car may be parked properly at the time of the accident. The insurance companies also favor putting more teeth in our present Financial Responsibility Law by providing for suspension of registration upon failure to pay a judgment, by requiring proof of financial responsibility to be furnished before such suspension can be removed even when judgment is paid, by reducing the limits of insurance required as proof to the standard limits, by requiring that the liability of the insurer shall become absolute, in so far as the victim is concerned, upon the occurrence of an accident, and by making the requirement of proof mandatory.

What plan of automobile insurance do you favor? The Journal welcomes your comments. Our Executive Secretary has spent many hours in conference on this problem and the subject deserves your intelligent interest.— *The Editor.*



## ... PROGRAM ...

# 147th Annual Meeting - - Connecticut State Medical Society

Hotel Taft, New Haven, May 25 - 26, 1939

At the morning sessions there will be two discussion periods each day allowing an opportunity for questions upon the papers just presented. As noted in the program, the discussion will be conducted in each case by a guest speaker.

All section meetings will be held in the Hotel Taft. Following the Section on Obstetrics the members of the Section and their friends will be the guests of Dr. Emerson Stone at a musicale given in his home.

The obstetricians will convene for dinner on the evening of May 26 and will be privileged to have as their guest Dr. Edwin F. Daly, Director of the government money spent for maternal and child welfare throughout the states under the supervision of Dr. Martha Elliot.

### May 25, 1939

- 9:00 Movie, "Modern Treatment of Burns—Reduction in Death Rate".  
Dr. Roy McClure, Detroit, Michigan, Surgeon-in-Chief, Henry Ford Hospital.
- 9:30 Treatment of Wounds.  
Dr. Arthur H. Bissell, Stamford, Attending Surgeon, Stamford Hospital.
- 9:55 The Factor of Delay in the Recognition of Common Surgical Conditions.  
Dr. Edward Ottenheimer, F.A.C.S., Willimantic, Surgeon-in-Chief, Windham County Memorial Hospital.
- 10:20 Essentials in Fracture Treatment.  
Dr. J. Leonard Vickers, Greenwich.
- 10:45 Summing-up Discussion.  
Dr. Arthur Allen, Boston, Chief, East Surgical Service, Mass. General Hospital. Lecturer in Surgery, Harvard Medical School.

### Intermission

- 11:30 The Problem of Cleft Lip and Cleft Palate.  
Dr. Claude C. Kelly, Hartford.
- 11:45 Urogenital Deformities.  
Dr. Chris Neuswanger, Waterbury.
- 12:00 Congenital Orthopedic Deformities.  
Dr. Arthur S. Griswold, Bridgeport.
- 12:10 Management of Congenital Defects of the Nervous System.  
Dr. William H. German, Associate Professor of Surgery, Yale Medical School.
- 12:30 Summing-up Discussion.  
Dr. Thomas Lanman, Boston, Mass., Visiting Surgeon, Children's Hospital, Boston. Assistant Professor Surgery, Harvard Medical School.

### May 26, 1939

- 9:00 Movie, "The Essentials of Pelvimetry."  
Dr. Herbert Thoms, New Haven.
- 9:30 Rational Therapy.  
Dr. Carl Wies, New London.
- 9:55 Vaccines of Value.  
Dr. Sidney S. Chipman, Norwalk.
- 10:10 X-ray Fallacies.  
Dr. Berkley M. Parmelee, Bridgeport. Radiologist, Bridgeport Hospital.
- 10:30 The Apical Cavity in Pulmonary Tuberculosis.  
Dr. R. Glen Urquhart, C.M., F.A.C.S., Norwich, Surgeon-in-Chief, Uncas-on-Thames.
- 10:40 Sulphapyridine in the Treatment of Pneumonia.  
Dr. Francis Blake, New Haven, Sterling Professor of Medicine, Yale Medical School.

## 11:00 Summing-up Discussion.

Dr. Chester S. Keefer, Boston, Associate Professor Medicine, Harvard Medical School; Associate Physician, Thorndike Memorial Laboratories, Boston City Hospital.

**Intermission**

## 11:30 Treatment Procedures for Cancer of the Uterus Advised by The Connecticut Tumor Clinics.

Dr. James R. Miller, Hartford, Obstetrician and Gynecologist, Hartford Hospital.

## 12:00 Dysmenorrhea.

Dr. Carl Johnson, New Haven.

## 12:30 Summary of Gynecological and Obstetrical Papers.

Dr. John Fraser, Montreal, Canada, Professor Obstetrics and Gynecology, McGill University, Montreal. Obstetrician-in-Chief, Royal Victoria Hospital.

**\*Section Assignments****May 25, 1939**

2:00 Orthopedic Section.

2:00 Connecticut Hospital Association.

2:00 Connecticut Occupational Therapy Society.

4:00 Section on Proctology.

4:00 Section on Radiology.

4:00 American Society of Anesthetists meeting with Section on Anesthesia.

4:00 Connecticut Branch American Association of Medical Social Workers.

**May 26, 1939**

2:30 Section on Obstetrics — to follow the President's Luncheon.

2:30 Section on Eye, Ear, Nose, and Throat — to follow the President's Luncheon.

4:00 Section on Dermatology and Syphilology.

4:00 Section on Neurology and Psychiatry.

4:00 Hezekiah Beardsley Pediatric Club of Connecticut.

4:00 Women's Medical Society.

7:30 Connecticut Medical Examiners.

\*Detailed program to appear in the May issue of The Journal.

**ASSOCIATION OF CONNECTICUT TUMOR CLINICS**

(Continued from Page 179)

Metastases from pharyngeal cancer are usually unsuited for surgery because of their frequent high degree of malignancy, their rapid growth, their wide irregular and frequently bilateral distribution, such as in the posterior triangle of the neck, under or behind the upper end of the sterno-mastoid muscle and in the lower neck just above or partly under the clavicle.

Coutard and Martin have called attention to the better prognosis in women with mouth carcinoma.

Slightly better results are noted in the higher age group. Our figures tend to corroborate these findings.

Palliation by radiation is usually the case in the unsuccessful group but occasionally patient may be made more miserable, when faulty judgment is used, as in an attempt for a curative result in a too far advanced condition.

Dr. Ewing's aphorism seems most appropriate for a closing remark on cancer of the oral cavity:—"The first treatment decides the fate of the patient."

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Watson, William.: "Adenocarcinoma of Oral Cavity." American Journal of Roentgenology & Radium Therapy, July, 1935.

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Martin, Hayes E.: "Diagnosis and Curability of Intra-Oral Cancer." Rocky Mountain Medical Conference, Denver, Colo., July, 1937.

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Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

**ILLUSTRATIONS** — Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

**NEWS.**— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

**ADVERTISEMENTS.**— All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

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## • Editorials •

### IMPORTANT BUSINESS !!

The Council of the State Society at a special meeting held in Hartford on March 22 voted to recommend to the House of Delegates that the annual dues be increased to \$15.00 per annum beginning with January 1, 1940, this increase to be for the purpose of employing a full time secretary for the Connecticut State Medical Society.

The Chairman of the Council requests your attendance at your own County Medical Association annual meeting to discuss this matter and to instruct your delegates to the State Society. Make it your business to be present. It is important.

—☆☆—

### SULFAPYRIDINE

Since the introduction of sulfanilamide chemists have sought for a derivative of this drug which would be as effective against pneumococcal infections as sulfanilamide has proved to be against hemolytic streptococcal diseases. The most promising of these is 2-(para-aminobenzenesulphonamido) pyridine, now generally called sulfapyridine, developed by May & Baker, Ltd., in England and originally reported upon by Whitby<sup>1</sup>. After a period of extensive and well controlled clinical investigations, which appear to indicate that sulfapyridine is of definite therapeutic value in the treatment of pneumococcal infections, particularly lobar pneumonia, at least when used promptly after onset of the disease, sulfapyridine has recently been made available for general use by the profession.

It is important, therefore, that physicians be cognizant not only of the fact that the drug appears to be therapeutically effective in pneumococcal infections but also of the problems encountered in its administration and particularly of the untoward reactions that are to be expected and have been met with in its use.

Although much is yet to be learned concerning the most appropriate dosage, the concentration in the blood necessary for therapeutic

effectiveness and the frequency and seriousness of untoward effects, it may be tentatively stated that for adults an initial dose of 2.0 gms. *per os*, followed by 1.0 gms. every four hours, has generally proved satisfactory and within twenty-four hours has established a supposedly desirable blood level of 6 - 10 mgm. per cent. How long the drug should be continued after apparent clinical recovery in order to forestall relapse is uncertain, though a few days with diminishing doses would appear to have been adequate in most instances.

The most frequent problem encountered in administering sulfapyridine *per os* is nausea and vomiting which usually begins very promptly, when it occurs, and has been encountered to a greater or less extent in about 50 per cent of cases. Not only may this prevent the prompt establishment of an adequate concentration in the blood but in perhaps 20 per cent of cases be so disturbing as to contraindicate further administration of the drug. Under these circumstances or others which prevent oral administration, the drug may be given by hypodermoclysis in equal volumes of normal saline and 5 per cent glucose solution<sup>2</sup>. If 1500 cc. of saline and glucose solution be brought nearly to a boil, 2.0 gms. of pure sulfapyridine powder be added, and the solution be allowed to cool to body temperature, no difficulty is encountered in giving the drug subcutaneously by this method. Two or three treatments every 24 hours seem to maintain an adequate blood level and nausea and vomiting usually stop promptly.

The untoward reactions that may be encountered are in general similar to those met with in the use of sulfanilamide, namely, drug fever usually with a more or less extensive maculopapular morbilliform rash occurring in perhaps 5 - 10 per cent of cases, usually five to eight days after the beginning of treatment; acute hemolytic anemia of uncommon occurrence, and developing within a few days after institution of treatment; acute neutropenia which has been encountered within the first week of treatment; and cyanosis during the treatment, probably of little consequence.

One additional untoward reaction rarely if ever seen with sulfanilamide, is an acute, sudden hematuria which may vary from an asymptomatic, microscopic hematuria to a gross hematuria with fairly severe colic. This may occur

in 5 to 10 per cent of patients, appears about the fourth day and lasts for two to five days.

Obviously, the nature and frequency of the untoward reactions require careful supervision of patients under treatment with sulfapyridine in order that the drug may be stopped immediately, when they occur. Under these conditions these reactions would generally, at least, appear to clear up fairly rapidly without any permanent injury. They also clearly indicate that sulfapyridine at present should be limited to the treatment of pneumococcal infections, at least until it is determined whether or not it possesses any advantages not possessed by sulfanilamide in other types of infection. Finally, it would appear too early to abandon the use of antipneumococcal serum in favor of sulfapyridine, until much more extensive experience has determined whether sulfapyridine is comparable to serum in therapeutic effectiveness, particularly in the severer, bacteremic pneumonias.

1. Whitby, L. E. H.: *Lancet* 1: 1210 (May 28) 1938.
2. Haviland, J. W. and Blake, F. G. (unpublished observations).  
F. G. B.



### TUBERCULOSIS CASE FINDINGS

Vital statistics have shown in the past twenty years a constantly falling death rate in tuberculosis in all forms. In 1910, the death rate for this disease in Connecticut was over 200 per 100,000 of the population. Since 1935, the death rate has been under 40 per 100,000 population. Curiously enough, however, in spite of this mortality drop, the State Tuberculosis Sanatoria continue to report over 60% of their admissions to be in the far advanced stage of the disease. A number of reasons, some of them controversial, are responsible for this condition, but it is generally agreed that delay in diagnosis is the chief cause that allows this situation to exist.

In the past few years there have been many contributions on Tuberculosis Case Finding Programs in the medical literature. Such programs are concerned primarily with the detection of tuberculosis in its early stage. Since every case of tuberculosis presupposes another case, as the source of the infection, quite naturally the obvious procedure is to examine those who have been in contact with the individual diagnosed as tuberculous.



Considerable emphasis has been placed upon the necessity for examining young adults of the high school age. No one can question the value of this procedure, but it should also be emphasized that it is the experience of those who have done a considerable amount of case finding work, that the highest percentage of manifest tuberculosis has been found in the older age groups.

Too frequently the early case of pulmonary tuberculosis cannot be diagnosed by physical examination. The lesion may not be accompanied by symptoms and percussion will not reveal impairment or dullness, nor will auscultation reveal to the ear rales or abnormal respiratory signs. Contacts and suspicious cases should have an intradermal tuberculin test and if a positive reaction is obtained the chest should be X-rayed.

Tuberculin can be obtained from a number of reliable pharmaceutical houses and the physician can as readily perform this test in his office as the Schick test for diphtheria.

On another page in this issue, the reader will find information on a sound film, recently released by the National Tuberculosis Association. This film presents, in an interesting and instructive manner, valuable information concerning the tuberculin test and the early diagnosis of tuberculosis.

H. B. C.



### A CHALLENGE TO THE COUNTIES

Perennially, with the approaching spring, appear the Annual Meeting programs of the eight County Medical Associations of Connecticut. This is no new custom for the history of many of these groups may be traced back one hundred and fifty years. Then, as now, these meetings afforded a much needed respite from routine practice in order to gain a new perspective; they offered an opportunity to increase medical knowledge and contributed in the exchange of greetings, anecdotes and pleasantries, a necessary recreational element. Today, more than ever before, in the face of swiftly moving events and rapidly progressing science should we maintain that custom of convening and dining together, for it has been said that

one cannot dislike another man with whom he has dined.

Has the County Association become less essential with the increasing efficiency of the State Society organization? Quite obviously the answer is in the negative. Each County Association has a very definite function, varying only slightly from its neighbors, due perhaps to locale and size, which may or may not be indicative of its particular problems. Each county, regardless of area, is entitled to its vote in the General Assembly and has a voice in all matters pertaining to the public welfare.

There are certain concrete ways in which the County Association may increase its activities the better to serve the needs of the people within its boundaries. It should (1) supply leadership in local health interests; (2) make available from its membership speakers for lay organization meetings; (3) secure representation in civic bodies; (4) offer intelligent cooperation with the lay press; (5) contact representatives of State and Federal government to promote a better mutual understanding in matters of health.

During the past decade increasing problems have brought the physician in closer contact with the attorney, the dentist, the pharmacist and the hospital executive. Educational leaders, business men and civic officials, as well as many civic groups, have signified their readiness to cooperate with the County Associations in the interest of better health. Is YOUR Association availing itself fully of these opportunities, does YOUR county make use of the media of platform, press and radio to keep its lay members fully informed in matters pertaining to public health?

The Annual Meetings are at hand and offer renewed opportunities for accomplishment as well as for discussion.



### AT THE HALF CENTURY MARK

The principles of aseptic surgery were announced to a skeptical medical profession a little more than seventy years ago. The memory of the carbolic acid spray then described remains as a relic of medical progress. That one of our own Connecticut physicians is still ac-

tively engaged in the practice of medicine and recounts from personal observation this epic transition in surgery, we feel is a notable fact. To illustrate the state of surgical technique when he was still a medical student, this man relates the following incident which occurred while he was administering an anesthetic. The Chief Surgeon of the old New York Hospital found it a convenience to slip the needle threaded with linen through the coat of his assistant in order to have it readily available for approximating his tissues. Somewhat irritated on one occasion, he reached for the needle and snorted, "Sir, it seems to me you are most valuable as a pin cushion."

Born in the Connecticut town of Essex, October 29th, 1859, this boy engaged the attention of Dr. Charles Hubbard, who recognizing his potential ability as a practitioner, volunteered to act as his preceptor without fee. Thus Elias Pratt began the study of medicine. He has practiced in the city of Torrington for more than fifty years. His regard for the signal service rendered by Dr. Hubbard is given as his reason for not returning to his native village to practice medicine. His ancestry is traced back to John Pratt who founded the blacksmith shop in Essex in 1678. An unbroken line of successive generations has continued this enterprise up to the present day. High school education was secured in Middletown and Hartford. Because of family finances it seemed impossible for him to secure a college education. Securing work in Ivoryton in an ivory piano key factory, he recited to Dr. Hubbard two evenings a week passages from Quain's Anatomy and discussed observations which he had made from the study of a borrowed skeleton.

Stimulated by his contact with Dr. Hubbard he sought more information at the College of Physicians and Surgeons of Columbia University in New York City where he matriculated in 1884. The school was then situated at 23rd street and Park Avenue and the terms began in October and ended in May. After graduating in 1887 he interned for a period of eighteen months at the Blackwell Island Hospital. When he began his service, iodine for preparation of the patients' skin was first being substituted for the carbolic acid spray previously

mentioned. He was married in 1890 to Maria Blake and has one son. From 1889 to 1891 he was Representative from Torrington to the Connecticut Legislature. While in the House he served on the Committee of Public Health and Safety. He was elected president of the Connecticut State Medical Society in 1923. He also served two terms as president of the Litchfield County Medical Association. His selection as president for a second term was made in order that he might be prominent in the celebration of the one hundred fiftieth anniversary of the founding of that society.

When asked his opinion as regarding social medicine, Dr. Pratt replied, "I do not favor any form of government control of medicine; however, under certain circumstances I think the government should provide funds for medical care, but the control and management of these operations should remain in the hands of the physician."

F. A. S.



## SPAS AND HEALTH RESORTS

The January issue of Archives of Physical Therapy contains an interesting report on Spas and Health Resorts, submitted by a committee of the American Congress of Physical Therapy. This committee received 70 replies to 152 questionnaires sent out to this type of health resort in the United States. Although the data is incomplete, due to poor returns in the Middle and Far West, there are several interesting observations to be noted. Nine institutions are under direct government control and supervision, either by the Federal, State Government or Municipal administration, the remaining 61 are privately owned and operated. In practically 10% of the places only, direct medical control is carried out by physicians employed by the institutions, the remaining resorts have only partial or no medical control.

This committee feels that there is a definite lack of knowledge and consequently a lack of interest by physicians regarding the use of spa facilities, because reliable information is not available from sources which carry authority and because proper use of the spa and climatic treatment is not taught in our medical schools.



# From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street

New Haven

The Executive Secretary has had the opportunity to serve as the only physician member of a Committee appointed by the Governor of the State to inquire into the subject of compulsory financial responsibility for motorists. As a result of participation in the conferences of this Committee the following tentative report and comment is made.

**1. The Problem.** "Injury or death in a motor vehicle accident means economic loss to the person injured and to the dependents of one who is killed. The incidence of this loss presents the problem of motor vehicle accident compensation. If the persons injured or the families of those who are killed receive no compensation for their economic loss, or if they receive compensation which does not cover the loss, or if the compensation is too long delayed, all or part of the burden is borne by them and in many cases by their doctors, hospitals, landlords and tradesmen. If adequate and prompt compensation is received, the full burden is borne by the motorist or by his insurer." With this definition in mind the problem should be viewed quite objectively as a social project rather than a project in which any selfish interest is involved. In the deliberations of the present Committee it became quite clear that members of the Committee who were best equipped to bring a thoroughly objective point of view to the subject favored some form of required financial responsibility while the various trade and insurance interests were opposed thereto. It may, of course, be said that physicians and hospitals would benefit by compulsory financial responsibility laws but it is also believed that physicians, particularly because of their frequent and intimate contact with the victims of motor vehicle accidents, are prompted to favor financial responsibility from a purely humanitarian point of view quite as much as from that of personal gain that might accrue.

**2. Opinion of Physicians.** As the representative of the Connecticut State Medical Society in this conference the expression of opinions herein is based upon a recent questionnaire, (February 1939) sent to members of the Connecticut State Medical Society inquiring the opinion of the principle of compulsory financial responsibility. *Less than one per cent of the physicians replying were opposed to compulsory financial responsibility.* The fact that physicians are concerned with the care and treatment of persons injured in motor accidents might lead one to the ready conclusion that physicians would, for that reason, favor compulsory liability. However, a review of the identity of the physicians answering the questionnaire shows that hardly more than ten per cent of those who did answer are engaged in the care of victims of automobile accidents.

**3. Effect on Accident Incidence.** The principle of compulsory financial responsibility has been freely criticised in the Committee's conferences on the ground that it would tend to increase accidents. It is argued that persons who do not carry insurance will tend to drive carefully because they fear personal liability for injury and when they are forced to insure they lose the restraining influence exerted by this fear of liability. This is a common argument against compulsory liability insurance made by insurance men who favor "tightening up" the financial responsibility laws which would require unwilling motorists to insure after an accident, even though they have given evidence of reckless driving.

The available results of many studies clearly show that there is no satisfactory evidence that compulsory insurance has affected highway safety either to increase or decrease the number of accidents and such an argument appears to be without merit.

**4. The Massachusetts Law.** Any discus-

sion of this subject, and there are those who have been interested in it for many years, invariably revolves around the "Massachusetts Law" which went into effect in 1927. One constantly hears of weaknesses in that law and blunders in its administration and because of the experience in Massachusetts, which is reputed to be unfortunate, the whole principle of the compulsory financial liability is condemned. This point of view is not easily accepted for, as a member of this Committee has asked, if the Massachusetts Law is as bad as it is said to be why has it not been repealed at one of the times that proposals for its repeal have been before the legislature of the State of Massachusetts? Moreover, it should not necessarily follow that even though the experience in Massachusetts has not been all that could be desired, that a better and more workable plan could not be devised for the State of Connecticut. Also it is not easy to agree that Connecticut should "go slow and wait for other states to experiment." By this it is not implied that this state should rush headlong into ill-advised legislation but it would be unwise for the state to remain quiescent and not direct its attention to the problem.

**5. The Compensation Plan.** Admitting that a form of compulsory financial responsibility is desirable the compensation plan seems to offer many advantages. Involving as it does the principle of "liability without fault" it will arouse hot debate. This principle has already been established in Sweden, Denmark, and Finland with respect to motor vehicle accidents and it is not an entirely new doctrine in our law for it has been embodied in workmen's compensation statutes for many years. It may be far-reaching legislation to have proposed for this state and further inquiry into its application is desirable. And to that end it is suggested that no broad revision of existing Connecticut law be made by the present General Assembly but that an official group be directed to concern itself with such a proposal, carrying on the study that was so wisely made by a previous commission and allow the fullest public discussion during the next two years.

## COUNTY MEDICAL ASSOCIATIONS ANNUAL MEETING PROGRAMS

### Fairfield

Tuesday, April 11 — Stratfield Hotel, Bridgeport.

4 P.M. Business meeting.

Dinner (following business meeting).

Speaker: Dr. Albert E. Austin, Member of Congress.

### Hartford

Tuesday, April 4 — Hunt Memorial Building, Hartford.

4:30 P.M. Business meeting.

7:00 P.M. Dinner, Hartford Club. Speaker: Louis S. Goodman, M.D., Yale University Medical School. Subject: Recent Developments in the Therapeutics of Pain.

### Litchfield

Tuesday, April 25 —

### Middlesex

Thursday, April 13 — Edgewood Country Club, Cromwell.

5:00 P.M. Business meeting.

5:30 P.M. Speaker: Lewis W. Brown, M.D., Newark, N. J. Subject: Allergy in General Practice.

6:30 P.M. Dinner.

Speaker: Prof. George M. Dutcher, Wesleyan University. Subject: Since Horse and Buggy Days.

### New Haven

Thursday, April 27 —

### New London

Thursday, April 6 — Seaside Sanatorium, Waterford.

6:15 P.M. Dinner.

Speaker: Samuel J. Kopetzky, New York City. Subject: Socialized Medicine.

### Tolland

Tuesday, April 18 — Olde Homestead Inn, Somers.

6:30 P.M. Dinner.

Speaker: James Raglan Miller, M.D., Hartford. Subject: Office Gynecology.

### Windham

Thursday, April 20 — Kingwood Hotel, Danielson.

4:30 P.M. Business meeting.

7:00 P.M. Dinner.



### NEW PREVENTIVE AGAINST GONORRHEA AND SYPHILIS

A most unusual report appeared in the February issue of the Journal of the Oklahoma Medical Association by Porter, Witcher and Knoblock in which the use of an oil designated as progonasyl is used for the prevention of gonorrhea and syphilis. The oil is a combination of triethanolamine, mineral oil, oleic acid, vegetable oil and organic iodine, is injected into the vagina and rapidly adheres to and covers all mucous membrane surfaces forming a tenacious jell. An hydrophilic colloid developed by the admixture of moisture from the nucus membranes, its viscosity is low and as it spreads rapidly it enmeshes and absorbs from diseased surfaces all debris and protozoal life, causing devitalization by means of desiccation or osmosis.

A series of experiments on human beings using controls was carried out to prove the efficacy of this oil as a preventive in both syphilis and gonorrhea. The authors believe this to be the first time that the female has been offered the protection of prevention by physical chemical means in relation to social diseases. About 400 females have been employed in these experiments and the authors report not the slightest deleterious action in any instance. The possibilities of using this contribution in diminishing the incidence of syphilis and gonorrhea would seem to be far reaching.



### SULFANILAMIDE IN TRACHOMA

The medical officers of the U. S. Bureau of Indian Affairs have launched a new campaign against trachoma among the Indians with this chemical compound. Trachoma is particularly prevalent among the Indians, much more so than among our white population. These endemic foci are responsible for from two to three thousand new cases annually with blindness resulting in about 17 per cent of cases. There are said to be thirty thousand cases among the Indians who number about 450,000. Out of 140 trachoma patients at the Rosebud Station in South Dakota treated by this method, 114 were reported as apparently cured. This gratifying result has inspired the Indian Bureau to an intensive campaign scheduled to have begun November 1st of this year.—*Wkly. Roster and Med. Dig.*, Dec. 10, 1938.

### SOUND FILM REGARDING TUBERCULOSIS

Dr. Hugh B. Campbell, President of the State Medical Society, announces that the State Tuberculosis Commission has available for county or local medical societies, a new sound movie entitled "Diagnostic Procedures in Tuberculosis". Four authorities on Tuberculosis do the talking in the 25-minute film, which is the first movie of its kind in sound produced by the National Tuberculosis Association and distributed in Connecticut by the State Tuberculosis Commission.

The doctors who participate in the film are Dr. Kendall Emerson, Managing Director of the National Tuberculosis Association, New York; Dr. Ralph S. Muckenfuss, Director of the Bureau of Laboratories of the New York City Department of Health; Dr. Esmond R. Long, Director of the Henry Phipps Institute, Philadelphia; and Dr. Edgar Mayer, Assistant Professor of Medicine, Cornell Medical College, New York.

Dr. Emerson is the narrator and in his introductory remarks says, "In the front line of the fight against tuberculosis is the general practitioner. He sees the patient first and upon his skill and judgment depends the patient's future. The greatest service he can render is to make the diagnosis correctly and without delay. There are certain diagnostic procedures every general practitioner is capable of carrying out." Dr. Emerson then introduces his speakers.

Dr. Muckenfuss demonstrates a simple technique of sputum examination. The making and reading of the tuberculin test is explained by Dr. Long. Dr. Mayer explains the X-ray as a means of diagnosing tuberculosis and the fundamental facts of X-ray interpretation.

Summing up, Dr. Emerson uses a diagram which shows the correlation between early diagnosis and prognosis.

Viewing the film is equivalent to attending a clinic and receiving expert counsel on the diagnosis of tuberculosis.

Showings of the film will be given without charge at any local or county medical association in Connecticut. An operator and full movie equipment will be supplied if desired. Write the State Tuberculosis Commission for complete details.

# Annual Report of the Treasurer

## OF THE CONNECTICUT STATE MEDICAL SOCIETY FOR THE CALENDAR YEAR 1938

To the House of Delegates:

Gentlemen:

I beg to report on the finances of the Connecticut State Medical Society for the calendar year 1938. Attached hereto is a report of the examination of the books and accounts of the Society made by Hadfield, Rothwell, Soule & Coates, Certified Public Accountants of Hartford which is open to the inspection of any member of the Society at its office in New Haven. A synopsis of this report with comments is given herewith.

It is fortunate that the expanding of our State Society's activities, with its increased expenditures, could have been met during the past year as it was with a comfortable margin because of a change in the collection of state taxes from the various County Societies. In the past these remittances have been sent after the calendar year was closed. It will be noted that the new arrangement, which calls for the forwarding of taxes by the tenth of each month after which they are collected, has brought two years of dues into the State treasury during 1938.

There has been worked out in connection with County Secretaries a much more accurate and up-to-date record of the payment of State taxes and it is now possible for our State office to keep track of counties where collections are delinquent.

The accountants have made certain recommendations which must be followed as promptly as possible. Some of these have to do merely with procedure but some call for more fundamental changes. The O. C. Smith Fund and its income are the only monies which are designated for special purposes, all others belong to the Society without restriction, including the

Russell Fund and the accounts of the Clinical Congress and of the Journal. For purposes of convenience these funds and even others may be handled in separate banks but the accountants rightly point out that "all receipts should be remitted to the Treasurer and all disbursements should be made by him on properly authorized vouchers. The practice of the various secretaries disbursing funds should be discontinued". In the statement they list \$5,130.83 as of December 31, 1938, as being not under the control of the Treasurer contrary to Chapter 6, Section 4 of the By-Laws. Your attention was called to this situation at the last annual meeting and steps will be taken to conform with the accountant's recommendation. They also suggest that County Secretaries remit to the State Treasurer the entire state tax and that the commission of 5% be returned by Treasurer's check.

Concerning the Russell Fund securities, though the statement shows a moderate depreciation (\$290.00) in market value, quotations as of March 8, 1939 indicate a recovery of approximately \$140 with advice that further recovery might well be anticipated.

The financial condition of the Society is sound, principally due to conservative management in the past and it is recommended that any enlargement of the program be provided for by appropriate increase in state taxes, leaving a comfortable balance to provide for each of our principal activities.

The burden of handling the complicated receipts and disbursements of the Society is an added reason for having a thoroughly competent central office organization.

Respectfully submitted,  
JAMES RAGLAN MILLER, M.D.

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## Exhibit A

Statement of General Fund Resources and  
Liabilities as of December 31, 1938

## RESOURCES

## Current Resources:

Cash on Deposit:

Under control of treasurer:

Union & New Haven Trust Com-  
pany, New Haven.....\$ 8,421.91

Gurdon W. Russell Fund:

Mechanics Savings Bank, Hart-  
ford, book #55057 ..... 1,602.98

\$10,024.89

Not under control of treasurer,  
contrary to Chapter 6, Section 4  
of by-laws:

Executive Secretary's account:

Second National Bank, New  
Haven..... 148.26Scientific Secretary, Journal ac-  
count:Capitol National Bank & Trust  
pany, Hartford:Due treasurer on ac-  
count of loan.....\$ 734.11

Balance..... 416.39 1,150.50

Clinical Congress ac-  
count:New Haven Bank,  
N. B. A. New Haven 525.18New Haven Savings  
Bank, New Haven.. 3,063.26

3,588.44

1939 Commercial Exhibit account:

Second National Bank, New  
Haven..... 243.63 5,130.83

Total Cash on Deposit..... \$15,155.72

Dues Receivable — 1938..... 123.50

Estimated Revenues — 1939 dues,  
payable January 1, 1939..... \$13,011.20

## Other Resources:

Gurdon W. Russell Fund:

\$8,000.00 par value of bonds,  
states at market values Decem-  
ber 31, 1937..... (A) 6,400.00

Total Resources..... \$34,690.42

## LIABILITIES

## Current Liabilities:

Appropriations continued in force,  
per Exhibit "C"..... \$ 7,481.51

## General Fund Surplus:

Under control of treasurer:

Represented by uncollected  
dues, loan to Journal, estimated  
1939 dues and other resources... \$19,534.70Cash surplus excess of cash on de-  
posit under control of treasurer  
over current liabilities..... 2,543.38

Total.....\$22,078.08

Cash surplus not under control of  
treasurer:

Clinical Congress....\$3,588.44

Executive Secretary.. 148.26

Scientific Secretary.. 1,150.50

1939 Commercial Ex-

hibit..... 243.63 \$ 5,130.83

Total General Fund Surplus.....\$27,208.91

Total Liabilities..... \$34,690.42

(A) Market value December 31, 1938 — \$6,110.00.

## Exhibit B

## O. C. Smith Trust Fund as of December 31, 1938

Assets Liabilities

## Cash on Deposit:

Mechanics Savings Bank, Hart-  
ford, Book 55673..... \$1,000.00Mechanics Savings Bank, Hart-  
ford, Book 134553..... 480.89(a)Reserve for O. C. Smith Trust  
Fund..... \$ 1,480.89

Totals.....\$ 1,480.89 \$ 1,480.89

(a) Represents accumulated interest on original fund  
which was segregated into a special account May 10, 1938.

## SCHEDULE 1

Treasurer's Cash Receipts and Disbursements for  
the Calendar Years 1938 and 1937Calendar Years  
1938 1937Cash on Deposit, Beginning of  
Year, per Prior Year Report:Hartford National Bank & Trust  
Company, Hartford.....\$ 1,150.96 \$ 2,853.14

## Receipts:

Dues 1937..... 7,807.75 6,997.31

Dues 1938..... 8,146.25 —

Gurdon W. Russell Fund — furni-  
ture..... 41.00 —Journal — partial payment on loan  
Annual meeting surplus (net of  
\$50.00 retained in fund)..... 625.76 —

Auto Emblems..... 178.10 291.20

Commercial exhibit..... — 2,108.78

Annual meeting expense refund... — 175.25

Miscellaneous..... — 47.13

Overcollections of dues 1938, per  
contra..... 7.00 —

Totals.....\$18,456.82 \$12,472.81

## Disbursements:

Executive Secretary.. \$4,842.87

Less: cash balance,

December 31, 1937.. 1,052.87  
3,790.00 4,595.00

Scientific Secretary — Journal... 3,858.30 2,497.22

Legislative Secretary..... 70.25 1,084.31

Annual meeting expenses..... 63.97 1,448.86

Dues refunded..... 54.75 7.60

Auto emblems.....	—	180.00
Printing and stationery.....	—	27.71
Typewriter.....	—	76.25
Treasurer's bond.....	—	12.50
Chairman of Council — traveling.	250.00	100.00
Exhibit — Tumor Committee...	200.00	58.29
Loan to Journal.....	—	1,234.11
Council meetings.....	101.80	—
Medical Examiner's Congress....	92.33	—
Delegates American Medical As-		
sociation meeting.....	569.13	—
Miscellaneous:		
Safe deposit box....\$	5.50	
Bond of treasurer...	12.50	
Insurance.....	13.35	
Auditing services....	684.52	
Miscellaneous.....	61.51	
Auto emblems.....	200.00	977.38
Overcollections of 1938 dues, re-		
funded.....	7.00	
Totals.....	\$10,034.91	\$11,321.85
Balance, End of Year, December		
31, 1937.....		\$ 1,150.96
Cash on Deopsit, December 31,		
1938, per Exhibit "A":		
Union & New Haven Trust Com-		
pany, New Haven.....\$	8,421.91	

SCHEDULE 2

Executive Secretary's Cash Receipts and Disbursements for the Calendar Years 1938 and 1937

SYNOPSIS

	Calendar Years	
	1938	1937
Cash on Deposit, Beginning of		
Year, per previous audit reports..\$	1,052.87	\$ 60.97
Total Receipts.....	5,469.96	5,591.10
(Including Cash on Deposit)		
Total Disbursements.....	5,321.70	4,538.23
Balance, End of Year, December		
31, 1937.....		\$ 1,052.87
Cash on Deposit, December 31,		
1938, per Exhibit "A".....\$	148.26	

SCHEDULE 3

Scientific Secretary, Journal Cash Receipts and Disbursements for the Calendar Years 1938 and 1937

SYNOPSIS

Cash on Deposit, Beginning of		
Year, per prior year audit report..\$	770.73	\$ 170.67
Total Receipts.....	10,854.88	6,379.83
(Including Cash on Deposit)		
Total Disbursements.....	9,704.38	5,609.10
Balance, End of Year, December		
31, 1937.....		\$ 770.73
Cash on Deposit, December 31,		
1938, per Exhibit "A".....\$	1,150.50	

SCHEDULE 4

Clinical Congress, Cash Receipts and Disbursements for the Calendar Year 1938

SYNOPSIS

Cash on Deposit, Beginning of Year.....\$	3,382.44
Total Receipts.....	4,685.82
(Including Cash on Deposit)	
Total Disbursements.....	1,097.38
Cash on Deposit, December 31, 1938, per	
Exhibit "A".....\$	3,588.44

SCHEDULE 5

Commercial Exhibit and Annual Meeting Receipts and Disbursements for the Calendar Year 1938

SYNOPSIS

Cash on Deposit, Beginning of Year.....\$	787.50
Total Receipts.....	3,605.00
(Including Cash on Deposit)	
Total Disbursements.....	3,361.37
Cash on Deposit, December 31, 1938, per	
Exhibit "A".....\$	243.63

SCHEDULE 6

Gurdon W. Russell Fund

Cash Receipts and Disbursements for the Calendar Year 1938

Cash on Deposit, December 31,	
1937, per prior year report:	
Mechanics Savings Bank, Hart-	
ford, Connecticut.....	\$ 1,340.93

Receipts:

Interest:	
On bonds.....\$	267.50
On bank balance.....	35.55
Total.....	\$ 1,643.98

Disbursements:

Transferred to general fund for	
purchase of furniture.....	41.00

Cash on Deposit, December 31,	
1938, per Exhibit "A":	
Mechanics Savings Bank, Hart-	
ford, Connecticut.....	\$ 1,602.98

This fund consists, in addition to the above savings account, of the following:

Market Value  
Dec. 31, 1938

\$5,000.00 par value, Connecticut Railway & Lighting Company, 4½% first refunding mortgage bonds, due January 1, 1951, stamped — \$108.00 bid.....\$	5,400.00
\$2,000.00 par value, Consolidated Railway Company (N. H.) 4% debenture bonds due July 1, 1954, last coupon paid (50%) of January 1, 1936) — \$9.00 bid.....	180.00



\$1,000.00 par value, Boston & Albany Railroad Company, 4¼% Improvement bonds, due August 1, 1978, \$53.00 bid . . . . . 530.00

Total . . . . . (A) . . . \$ 6,110.00

(A) For purposes of this report, the books have not been adjusted to reflect market values December 31, 1938, as shown above.

#### SCHEDULE 7

##### O. C. Smith Trust Fund

##### Cash Receipts and Disbursements for the Calendar Year 1938

Cash on Deposit, December 31, 1937, per prior year report . . . . . \$ 1,528.27

Total Receipts . . . . . 1,568.89  
(Including Cash on Deposit)

Total Disbursements . . . . . 88.00

Cash on Deposit, December 31, 1938, per Exhibit "B" . . . . . \$ 1,480.89

## SECTION ON Orthopedic Surgery

### Bill Requiring Emergency Equipment in Ambulances Defeated

A trial balloon in the form of a bill was introduced into the legislature and was heard in committee during the past month. This bill purported to compel all ambulances in the state to carry proper emergency equipment including traction splints and also to have properly trained attendants on the ambulances. The bill died in committee because of the tremendous opposition on the part of ambulance owners who are chiefly undertakers in the State of Connecticut. This complete lack of appreciation of the problem on their part will require considerable educational effort on the part of the committee before the next legislature convenes.

### New York and Brooklyn Fracture Committee Meeting

On February 24, 1939, seventeen members from Connecticut attended this very interesting

meeting. Through error, the names of Dr. Crosby and Dr. Lindsay were omitted from the speakers' list in the last issue under this section. Dr. Lindsay read a paper on "The Treatment of Fractures of the Humerus in Children and Adults". Incidentally, the national chairman complimented the work of the Connecticut Fracture Committee and placed it first on the list of those that are most active.

### Spring Meeting of the Connecticut Fracture Committee

On April 27 at the Hunt Memorial in Hartford, an excellent program will be presented by a number of the outstanding orthopedists of the state and surrounding communities. All members, as well as anyone who is interested in the treatment of fractures, are urged to attend. A business section will consume the morning and the scientific program will be presented in the afternoon.

### Boston Fracture Committee Meeting

The Boston City Fracture Committee will hold their spring meeting on April 14 and 15. Everyone is urged to attend so that Connecticut will have as large a representation as possible.

### Clinical Congress — New Haven

A three-day course on fracture treatment will be presented by the committee at the Clinical Congress in New Haven this September. This promises to be an excellent refresher course with plenty of time to be devoted to discussion of fracture problems. Everyone interested in fracture treatment should come and bring his fracture problems for discussion.

### Meeting of Section

The program will be announced in the next issue of the Journal for the Sectional Meeting together with the Connecticut State Medical Society meeting in New Haven during the month of May.

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## SECTION ON Proctology

The proposed Section on Proctology of the Connecticut State Medical Society will meet at 4 P.M., on May 25, 1939 at the Hotel Taft, New Haven. This meeting will be held in conjunction with the annual meeting of the State Society on that date. The speaker will be Dr. A. W. Martin Marino, F.A.C.S., of Brooklyn, New York. Dr. Marino is a Fellow of the American Proctologic Society and his subject will be "Anorectal Tuberculosis". The paper will be discussed by Dr. R. Glen Urquhart, C.M., F.A.C.S., chief surgeon of the State Tuberculosis Hospital at Norwich.

Following the paper a short business meeting will be held for organization.

The spring meeting of the New England Proctologic Society is scheduled to be held in Worcester, Massachusetts, on April 21 and 22. For information regarding the program and admission requirements, those interested are requested to write to Dr. Frederick S. Ellison, 50 Farmington Avenue, Hartford, Connecticut.

Word was received recently of the death of Dr. Raoul Bensaude of Paris, France. Dr. Bensaude was probably one of the best known proctologists, and was beloved by all who had the opportunity of studying under him or visiting his clinic in the L'hôpital Saint-Antoine in Paris. Best known of his books is the *Traité D'Endoscopie* which is most valuable as an atlas of lesions of the anorectal region.

The annual meeting of the American Proctologic Society will be held at the Hotel St. George, Brooklyn, New York on June 25-27, 1939. Dr. Wm. H. Daniel of Los Angeles will review the literature on malignancy of the colon and rectum while Dr. George Thiele of Kansas City will review benign diseases. If available, the rest of the program will appear in a later issue of the Journal.

Following the Brooklyn meeting, a large number of the members will embark to attend a joint meeting with the sub-section on Proctology of the British Medical Society in London on July 10 and 11. Admission to the meetings is limited to Fellows and Associates of the Society and to guests sponsored by the members.

## LECTURE SERIES AT NEURO-PSYCHIATRIC INSTITUTE OF HARTFORD RETREAT

The annual Lecture Series at the Neuro-Psychiatric Institute of the Hartford Retreat this year brought some of the leading physicians and psychologists of the country to Hartford to speak to the Medical Staff of the Institute, and to Connecticut psychiatrists and neurologists who were invited to attend.

The Lectures were designed to keep members of the Institute Staff in contact with later developments, not only in the fields of psychiatry and neurology, but in other closely allied branches of medicine.

The Series opened on November 2nd with Dr. Lawrence Kolb, Assistant Surgeon General of the United States speaking on "The Drug Addict and What is Being Done About Him", and will continue through to March 29 when the concluding lecture will be given by Dr. G. Edward Hall of the Banting Institute, Toronto, who will discuss research projects now under way at the Institute, with particular reference to insulin therapy.

Other speakers, and their subjects, are as follows:

Dr. Leland Hinsie, Professor of Clinical Psychiatry, Columbia University — Appraisal of Psychiatric Research.

Dr. Bernhard Dattner, of the Von Jauregg Clinic, Vienna — Technique of Fever Therapy.

Dr. Carney Landis, Research Associate in Psychology, New York Psychiatric Institute and Hospital — Prognosis for Insulin Therapy through Psychological Tests.

Dr. Richard Brickner, Assistant Professor of Neurology, Columbia University — Neurological Studies.

Dr. S. W. Ginsburg, New York — Psychoanalytic Technique.

Dr. Alexander Lambert, Professor of Clinical Medicine, Cornell University — Alcoholic and Drug Addiction.

Dr. Abner Wolf, Professor of Pathology, Columbia University — Neuro-Pathology.

Dr. Gregory Zilboorg, New York — The Psychology of Race Persecution.

Dr. J. B. Rhine, Professor of Psychology, Duke University — Extra-Sensory Perception.



Dr. Foster Kennedy, Professor of Clinical Neurology, Cornell University — New Trends in Medical Education.

Dr. Raphael Kurzrok, Professor of Gynecology, Columbia University — Male and Female Hormones.

Dr. Angus M. Frantz, New York — Studies in Allergy.

Dr. William G. Lennox, Professor of Neurology, Harvard University — Electro-Encephalography.

Dr. G. Edward Hall, Research Associate, Banting Institute, Toronto, Ontario — Research in Insulin Therapy.



## Our Neighbors

### MASSACHUSETTS

Curtis T. Prout, M.D., formerly Senior Psychiatrist at the Neuropsychiatric Institute of the Hartford Retreat, has been appointed Medical Director of the Ring Sanatorium and Hospital, Arlington Heights, Massachusetts. Dr. Prout succeeds Dr. Hosea W. McAdoo, who will enter practice in the South. Dr. Prout is a graduate of Cornell University, 1924, and received the degree of Master of Science, in Neurology, at the University of Minnesota, 1929. He was certified by the American Board in Neurology and Psychiatry in 1935. Dr. Prout comes to the Ring Sanatorium with an extensive experience, including clinical work in several hospitals and teaching appointments at Cornell, Albany and Columbia University Medical Schools.

### NEW JERSEY

The members of the Medical Society of New Jersey are in hearty agreement with the editorial in the New York Herald-Tribune of March 2 which states that the Wagner Bill in calling for an appropriation of \$80,000,000 for new hospi-

talization is asking too much. The health of the country does not demand such an expenditure. Senator Wagner's program is premature since we have not yet digested the social security services already in operation.

A Uniform Medical Practice Act was introduced into the New Jersey Assembly February 20. When last heard from the bill was in the Judiciary Committee of the Assembly. The bill contains four features: (1) full citizenship as a requirement of those who want to practice medicine or take the examination of the Board of Medical Examiners; (2) a standard of educational requirements, which in substance means that the chiropractors cannot be licensed to practice after 1940 unless they have the equivalent medical and professional qualifications required of all M.D.'s and of those Doctors of Osteopathy who qualify as legal practitioners of medicine and surgery; (3) definite additional reasons for the revocation of license; (4) real penalties for those who violate the medical practice act.

### NEW YORK

Results of the State medical examinations for 1937-38 announced January 28 by the State Education Department, showed that of 1,063 foreign doctors who tried the tests, 441 failed to pass. According to the department, 1,836 candidates took the examinations — 1063 from foreign schools, 285 from schools of other states, and 488 from New York medical schools.

The report showed that 5.5 per cent of the New York educated doctors failed in the tests and 24.9 per cent from other states failed.

Listed by country, number of candidates, and number of failures, results of the examinations follow:

Austria, 112 candidates, 35 failures; Germany, 422 candidates, 210 failures; Czechoslovakia, 12, 9 failures; England, 12, no failures; France, 36, 14 failures; Hungary, 12, 8 failures; Ireland, 7, 5 failures; Russia, 10, 9 failures; Scotland, 88, 14 failures; Switzerland, 181, 66 failures; Syria, 2, no failures; Italy, 103, 58 failures; Turkey, 1, 1 failure; Cuba, 2, no fail-

ures; Canada, 62, 11 failures; Mexico, 1, 1 failure.

A mass effort to curb tuberculosis among poverty-stricken families, through X-ray examinations of the 529,000 men, women, and children on home relief in New York City was announced recently by Mayor LaGuardia. No campaign of equal magnitude has ever been attempted in the past, the mayor told reporters after he watched four persons a minute pass before the X-ray machines at a W. P. A. tuberculosis clinic. The records kept will be "unusually complete," the mayor said, and a full check-up will be made on families and friends of those found infected.

The first full year of organized battle against pneumonia in New York City under the auspices of the Health Department's pneumonia control bureau was concluded on December 31.

Exact figures on the bureau's accomplishments will not be available for some time, but estimates show that the use of serum to fight the 60 per cent of pneumonia cases for which serum can be used, has been doubled.

A rough estimate on the number of lives saved would indicate that somewhere between 700 and 1,000 persons with pneumonia who would have died in 1938 are now alive, thanks to serum and its increased use under the pneumonia bureau.

Following the report of a recent death of an infant from lead poisoning traced to the use, by the child's mother, of a lead nipple-shield, the Public Health Council has adopted an amendment to the State Sanitary Code which prohibits the sale or use of such shields, according to an announcement by Dr. Edward S. Godfrey, Jr., State Commissioner of Health.

Westchester County is to have a Central Nurses Registry to supply directly or indirectly adequate nursing service to all who need it, in home or hospital. The Registry also aims to supply areas not now served by alumni registries, to supplement the services of alumni registries when necessary, to work closely with visiting nurse services and other health and social agencies, and to provide the services of registered nurses for private duty service, hourly nursing service, institutional nursing service, and for doctor's offices and other positions. The Registry will also provide practical

nurses, nurse attendants, technicians, dietitians and other medical workers.

## RHODE ISLAND

Fifty-nine per cent of the hospital care in Providence, R. I., and six neighboring towns during 1937, was furnished entirely free, a survey by the Providence Medical Association, published in *The Journal of the American Medical Association* for Feb. 11, reveals.

The survey is a part of the American Medical Association's study of the need and supply of medical care in the United States.

Other Rhode Island towns included in the Providence survey are Cranston, Barrington, Bristol, East Providence, North Providence and Warren.

The nine hospitals to which questionnaires were sent reported a total of 486,440 patient days of hospital care during the year. Of these, only 41 per cent were paid for in whole or in part.

Doctors who answered the survey had an average of eighty-five free patients each. "If we may be allowed to use this figure as a norm," the survey says, "it would appear that the physicians in the entire area cared for 10 per cent of the entire population free. The part pay group of the low income class, and the indigent group cared for by public welfare departments and state unemployment relief, are not included in this 10 per cent."

Pointing out that medical facilities are adequate in this district, the study states that there is a doctor available to every 774 persons, a dentist to every 1,576, and a nurse to every 500.

"Towns and communities outside the Providence City area are shirking their duty in not appropriating proper funds for the care of their own indigent who have need to be hospitalized and must be taken to a hospital in the Providence City district," the survey declares. "The responsibility for such problems rests with the individual communities, and it is hardly fair to complain against the hospital which refuses such cases, except in an emergency, unless the town accepts its share of the expense burden."

Dental care for all classes was a further need mentioned in the survey.



## - NEWS -

### *from County Associations*

#### Hartford

The new addition to St. Francis Hospital, the munificent gift of Miss Catherine H. Dillon in memory of her late brothers, Charles and Edward Dillon, is rapidly nearing completion. Mother Xavier, Superintendent of the hospital has not as yet picked out any date for the formal opening but it is expected that ceremonies suitable to this occasion will probably be held some time in June of this year.

Attesting to the seasonal importance of the subject and the interest in the new form of treatment was the unusually large number which attended the regular meeting of The Hartford Medical Society held on March 6, 1939. At this meeting a comprehensive review of an appreciable number of cases of pneumonia treated at St. Francis Hospital since December 1937 with sulfapyridine was given by Drs. Arthur B. Landry and Louis P. Hastings. Formal discussion was opened by Dr. Ernest Caulfield, followed by interesting and valuable general discussion.

"Recent Developments in the Therapeutics of Pain", will be the subject of a paper to be read by Lewis S. Goodman, M.D., Assistant Professor of Pharmacology and Toxicology, Yale University School of Medicine, at a meeting of The Hartford County Medical Association to be held at the Hunt Memorial Building in Hartford on April 4, 1939.

Births: Sally Jean Walton to Dr. and Mrs.

Lostus L. Walton, West Hartford, on January 28.

Douglas Hopkins Peacock to Dr. and Mrs. Albert U. Peacock, Hartford, on February 22.

E. Myles Standish, Jr., to Dr. and Mrs.

E. Myles Standish, West Hartford, March 5.

At the annual meeting of the staff of the Municipal Hospital, Hartford, held on March 14, H. L. F. Locke, Chairman, C. F. Vernlund, Vice-chairman, W. L. Hogan, Secretary, were all re-elected for the ensuing year. Richard E. Dunne resigned from the surgical staff and was

elected to the consulting staff. Joseph Heyman was elected to the vacancy caused by Dr. Dunne's resignation.

#### Middlesex

The Middletown Health Department has announced a campaign for the tuberculin testing of all sophomore high school students in the city and town school districts. Those with positive reactions are to be referred to their family physician for further study.

While many localities have had outbreaks of scarlet fever during the past few weeks the entire Middlesex county has been free of this disease.

Dr. Roy L. Leak, superintendent of the Connecticut State Hospital, recently took the legislators of the county on a tour of inspection of the hospital that they may be the better acquainted with the problems faced by the institution.

Recent improvements in the plant of the Middlesex Hospital consist in the installation throughout the entire hospital of an automatic vocal call system and an automatic sprinkler system. An inter-departmental dial system will be installed.

Dr. Ella A. Wilder of Middletown, president of both the Middlesex County and Central Medical Societies, has been convalescing in Florida from a recent illness.

The Central Medical Society was addressed on March 13th by Dr. Frank Potter of Middletown who spoke on his experiences during the past half-century in medical practice. His talk was most interesting and was well received. Officers for the ensuing year elected at this meeting were Dr. Harry S. Frank, President; Dr. Henry O. Colomb, Vice-President; Dr. Benjamin A. Roccapriore, Secretary, and Dr. Carl C. Chase, Treasurer.

The medical fraternities of the County joined with the Wesleyan faculty and the community at large in extending their sympathy to Dr. Edgar Fauver, physician to Wesleyan University, whose wife was taken by sudden death on Saturday, March 11.

Dr. A. N. Sweet, President of the Medical Board of the Middlesex Hospital, is attending the San Francisco Fair. He recently sent his greetings to the Medical Board.

Dr. F. Erwin Tracy of Middletown and Dur-

ham is attending a two weeks' course in Internal Medicine at the Johns Hopkins Hospital. This course is sponsored by the American College of Physicians.

Dr. Roy L. Leak of the Connecticut State Hospital reports that chiefly due to the reconstruction program at the hospital a condition of marked overcrowding exists. In one of the women's buildings the census has reached a point 53% above normal capacity.

The use of sulfapyridine in the treatment of lobar pneumonia at the Middlesex Hospital received considerable publicity recently in the lay press. Both its use and the manner of obtaining the drug were considerably dramatized.

Dr. William Tate of Deep River recently purchased a river-front home formerly used as a resort hotel. After remodelling, Dr. Tate plans on using this both for his home and office.

#### New Haven

At the first March meeting members of the New Haven Medical Association heard a discussion of legislation pending in Connecticut General Assembly by Dr. Creighton Barker, President of the New Haven County Medical Association and Executive Secretary of the Connecticut State Medical Society. The paper of the evening was presented by Dr. George F. Cahill, Associate Professor of Urology, Columbia University, on "Clinical Aspects of Adrenal Cortical Syndrome". On March 15 Dr. Samuel Kleinberg of the Hospital for Joint Diseases, New York City, addressed the New Haven Medical Association on the "Differential Diagnosis of Low Back Pains".

On January 26, the Waterbury Mental Hygiene Association sponsored a public forum at the Waterbury Medical Association Building on the subject of "Juvenile Delinquency in Waterbury," at which meeting Judge Conway, Miss Kathleen Crowley and Judge Mascolo were the speakers.

On February 9, the Waterbury Medical Association was addressed by William Jason Mixter, M.D., of the Department of Neurosurgery of Harvard Medical School and Visiting Surgeon of the Massachusetts General Hospital on the subject, "The Role of Neurosurgery in Epilepsy." The paper was discussed by Drs. James Charles Fox and Bernard Stephen Brody, both of New Haven.

Dr. Charles H. Best, Professor of Physiology and Associate Director of Connaught Laboratories University of Toronto, addressed the Yale Medical Society on Wednesday evening, March 8, on the subject "Heparin and Thrombosis". Dr. Best's return for an address in New Haven was particularly welcomed by those who recall his engaging lectures as visiting Professor of Physiology at Yale in 1936.

On Tuesday, February 28 in the auditorium of the Sterling Hall of Medicine Sir Aldo Castellani lectured on "Hygienic Measures and Hospital Organization in Tropical Expeditions with Special Reference to the Ethiopian Campaign of 1935-36." On Wednesday, March 1 the same speaker lectured on "Mycetes and Mycotic Diseases".

Yale University Alumni Day, February 22, found an unusually large number of physicians back to refresh themselves at the source of their wisdom and for livelihood. The bill-of-fare thoughtfully sent out by the administration to the alumni of the School of Medicine appeared at first sight to be a flash announcement of the World's Fair but inquiry revealed that it was simply a sample of the daily curriculum. About one hundred members of the Alumni Association almost filled the internes dining room of the New Haven Hospital at lunch time, the remaining places being readily taken by ringers from the School. The occasion was memorable for the thickness of the chops and the stark absence of speeches. Following inspection tours of museums and laboratories and visits to conferences, demonstrations, and clinics a general assembly in the Auditorium of the Sterling Hall heard Dean Stanhope Bayne-Jones discuss plans for the future of the School. President Charles Seymour of Yale University presented his cordial greetings to the Alumni and expressed the pride of the University in the achievements of the School of Medicine. Dr. Milton C. Winternitz presented the "Pathology of Arteriosclerosis," Dr. Francis G. Blake discussed "Sulfapyridine in Pneumococcal Infections," and Dr. Hugh M. Wilson discussed "Body Section Roentgenography." Promptly after the assembly the Alumni gathered in the Recreation Room of the Sterling Hall of Medicine and there joined by students and faculty of the School forthwith consumed a hoghead of refreshments. A happy time was had by all.



### Tolland

The semi-annual meeting of the Tolland County Medical Association will take place April 18 at the Old Homestead Inn, Somers. After the dinner, Dr. J. R. Miller will give a discussion on "Office Gynecology". Members are urged and non-members are invited to attend. Dinner will be at 6:30.

At a meeting of the Public Health Nurse Association, held March 28 at the East School, Rockville, a lecture was given by Dr. Foote and the film "Centerdale Grows Up" was shown. This deals with the work of the Visiting Nurse Association and will be shown in connection with the Public Health Program at the N. Y. World's Fair.

The sympathy of the members of the County Association is extended to Dr. Francis Burke of Rockville, whose father, F. H. Burke, died recently.

—☆☆—

## Letters to the Editor

### CONNECTICUT STATE EMPLOYMENT SERVICE

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February 21, 1939

To the Editor:—

During a recent call which I made to Dr. Joseph Linde to explain the purposes of the Conn. State Employment Service, he suggested that a letter to the State Medical Society would further explain our services to doctors.

The Conn. State Employment Service is an interviewing and selecting agency for all types of workers, including doctors' office assistants and certain technical workers. It acts as a clearing house for abilities and skills and saves employers' interviewing time when positions

must be filled. We have been able to serve several doctors in the past when they are seeking properly qualified office assistants or technicians and we believe that other doctors would be glad to know of our facilities.

The Conn. State Employment Service is maintained by the State of Connecticut under the Merit System and is entirely free to both employers and applicants. There are offices in eighteen cities in the state.

Should any vacancies or temporary positions arise in your offices, a telephone call stating the requirements of the position to the local office of the Conn. State Employment Service would bring a few selected and qualified applicants at your convenience. If we can be of service to you, please do not hesitate to call upon us.

Sincerely yours,

Conn. State Employment Service  
Frank Craddock, Mgr.

by: (Mrs.) Lois M. Salisbury  
Commercial-Professional Division

—☆☆—

### INFANT MORTALITY IN GERMANY

In Germany, which has had sickness insurance longer than any other nation in the world, the infant mortality rate is higher than in any state in the United States that is in any way comparable with Germany as to climate and racial uniformity, *The Journal of the American Medical Association* for December 17 reports.

In the *Deutsches Arzteblatt*, of October 1, 1938, Hans Klepp reports on "The Struggle Against Infant Mortality," and gives a table showing the course of infant mortality during the present century. Although showing a fairly consistent decrease in the death rate per thousand live births, the 1935 rate in Germany was 69. In eleven northern states that have been in the registration area since 1920, the range of the infant death rate per thousand in 1935 was between 41.2 for Oregon and 53.9 for New Hampshire, according to a summary issued by the Bureau of the Census of the United States Department of Commerce.

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## SPECIAL NOTICES

### FOUNDATION PRIZE ESSAY

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons announces that the annual Foundation Prize for this year will be \$100.00. Those eligible include only (1) interns, residents, or graduate students in Obstetrics, Gynecology and Abdominal Surgery, and (2) physicians (M.D. degree) who are actually practicing or teaching Obstetrics, Gynecology or Abdominal Surgery.

Competing manuscript must (1) be presented in *triplicate* under a nom-de-plume to the Secretary of the Association before June 1st, (2) be limited to 5,000 words and such illustrations as are necessary for a clear exposition of the thesis, and (3) by typewritten (double-spaced) on one side of the sheets, with ample margins.

The successful thesis must be presented at the next annual (September) meeting of the Association, without expense to the Association and in conformity with its regulations.

For further details, address Dr. James R. Bloss, Secretary, 418-11th Street, Huntington, W. Va.



### AMERICAN BOARD OF INTERNAL MEDICINE, INC.

Written examinations for certification by the American Board of Internal Medicine will be held in various sections of the United States on the third Monday in October and the third Monday in February.

Formal application must be received by the Secretary before August 20, 1939 for the October 16, 1939 examination, and on or before January 1 for the February 19, 1940 examination.

Application forms may be obtained from Dr. William S. Middleton, Secretary-Treasurer, 1301 University Avenue, Madison, Wisconsin, U. S. A.



### NEW ENGLAND HEALTH EDUCATION INSTITUTE

An extensive program presenting various aspects of health education has been arranged for the New England Health Education Institute to be conducted under the auspices of the New England Health Education Association, the State tuberculosis associations and departments of health and education in each of the six states at Massachusetts Institute of Technology in Cambridge, Mass., on April 21 and 22.

Of interest to school administrators, public health officials and community health workers the two-day meeting will feature a series of discussions, lectures and exhibits. Participating in the discussions to be held in the new William Barton Rogers Building will be leading health educators, psychologists, public health officials and medical men from many states.

One of the highlights on the program is the address on "Coordination of Medical and Health Services in a City" to be delivered at the general open meeting on the evening of April 21, by Dr. Henry D. Vaughan, commissioner of health, Detroit, Mich.

"How Can We Educate the Public to Secure Better Medical Care," is the subject Dr. Channing Frothingham, president of the Massachusetts Medical Society, will discuss at the luncheon meeting on that day, while Dr. Howard W. Haggard, director of the laboratory of applied psychology at Yale University, will speak before the luncheon meeting on April 22 on "Education and Personal Health."



### PREVENTION AND CARE OF PREMATUREITY Subject of Nursing Institutes\*

These institutes will be of interest to every physician who is engaged in general practice or who cares for obstetrical or pediatric cases.

Bridgeport — May 19, 1939

Hartford — May 22, 1939

Further details will be announced in the May issue of this Journal.

\*Sponsored by the Connecticut State Department of Health.



### INTERNATIONAL COLLEGE OF SURGEONS

The International Assembly of the International College of Surgeons will be held at the Hotel Roosevelt, New York City, May 22-24. The program chairman is Fred H. Albee, M.D., 57 West 57th Street, New York City.



### COMING MEETINGS

American Association of Anatomists, Boston, April 6-8. Dr. E. R. Clark, University of Pennsylvania School of Medicine, Philadelphia, Secretary.

American Association of Pathologists and Bacteriologists, Richmond, Va., April 6-7. Dr. Howard T. Karsner, 2085 Adelbert Road, Cleveland, Secretary.

American Pediatric Society, Sky Top, Pa., April 27-29. Dr. Hugh McCulloch, 325 North Euclid Ave., St. Louis, Secretary.

American Physiological Society, Toronto, Canada, April 26-29. Dr. A. C. Ivy, 303 East Chicago Ave., Chicago, Secretary.

American Society for Pharmacology and Experimental Therapeutics, Toronto, Canada, April 26-29. Dr. G. Philip Grabfield, 319 Longwood Ave., Boston, Secretary.

American Society of Anesthetists, New York, April 14. Dr. Paul M. Wood, 131 Riverside Drive, New York, Secretary.

# COMING MEETINGS (Cont.)

American Society of Biological Chemists, Toronto, Canada, April 26-29. Dr. C. G. King, Univ. of Pittsburgh, Dept. of Chemistry, Pittsburgh, Secretary.

Federation of American Societies for Experimental Biology, Toronto, Canada, April 26-29. Dr. D. R. Hooker, 19 West Chase St., Baltimore, Secretary.

Maine Medical Association, Poland Springs, June 25-27. Frederick R. Carter, 22 Arsenal Street, Portland, Maine, Secretary.

Massachusetts Medical Society, Worcester, June 6-8. Alexander S. Begg, 8 Fenway, Boston, Massachusetts, Secretary.

New Hampshire Medical Society, Manchester, June 8-9. C. R. Metcalf, 5 South State Street, Concord, New Hampshire, Secretary.

New York, Medical Society of the State of, Syracuse, April 24-27. Peter Irving, 2 East 103rd Street, New York, Secretary.

Rhode Island Medical Society, Providence, June 7-8, Guy W. Wells, 124 Waterman Street, Providence, Rhode Island, Secretary.



## ACUTE CORONARY FAILURE

(Continued from Page 171)

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1. C. S. Keffer and Wm. H. Resnik. Angina Pectoris (a syndrome caused by anoxemia of the myocardium). Archives of Internal Medicine, 41:769, June, 1928.

2. O. Klatz and W. Lloyd. Sclerosis and Occlusion of the Coronary Arteries. Canadian M. A. J., 23:359, Sept. 1930.

3. Samuel A. Levine. Clinical Heart Disease: W. B. Saunders Co., 1936, Page 125.

4. Paul Dudley White. Heart Disease. MacMillan Co., 1931, Page 617.



## COMPULSORY HEALTH INSURANCE

According to the New York State Journal of Medicine (April 1, 1938), recent events throughout the country should serve to reinforce the opposition of organized medicine to compulsory health insurance. In Oklahoma widespread nepotism and graft in the administration of old age and unemployment insurance have already come to light. Vast social security reserves are being used for unrelated Federal expenses. The health insurance group at Washington is still active and powerful and may yet attempt to accomplish its aims. Medical Societies all over the country are engaged in laying plans to provide medical care for all groups without the undesirable features of compulsory insurance.

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## • OBITUARIES •

### DR. HENRY EDWARD WATERHOUSE 1877 - 1939

Dr. Henry E. Waterhouse died on February 4th, 1939, at his residence, 44 Northwood Road, Bridgeport, Connecticut, of coronary occlusion after an illness of two days at the age of sixty-one years.

Dr. Waterhouse was a native of Centerville, R. I. He attended Brown University and graduated from Columbia University Medical School. He came to Bridgeport in 1905 and joined the Assistant Staff of the Hospital. He became Assistant Obstetrician in 1909, attending Obstetrician in 1911 and Chief Obstetrician in 1915. It was through his support that the Obstetrical Department of the Hospital was conceded to be one of the best, having developed it from the beginning.

As an Obstetrician he stood in the very front rank. For years before the Obstetrical Department at the Hospital was developed he was a welcome visitor to hundreds of homes where his skill and cheerfulness greeted many of the present generation.

Among the profession he was progressive in thought and action. Neither fads nor fancies in Obstetrics attracted him but he kept pace with moderate methods at all times.

He was a member of the New York Obstetrical Society, the American College of Surgeons, the American Medical Association and also State and County Medical Societies.

Surviving him is his wife, Minerva, a trained nurse and a daughter Jean; one sister, Mrs. George B. Coughlin of New York City.

His unexpected departure after so brief an illness occasioned sincere sorrow in many homes as well as to the profession he loved.

Stanton R. Smith, M.D.

## • Quarto Notes •

### PHYSIOLOGY OF THE NERVOUS SYSTEM

by John F. Fulton, M.D.  
Sterling Professor of Physiology  
Yale University School of Medicine  
\$6.00

New York Oxford University Press 1938

Written and dedicated to the medical student, this exhaustive presentation of experimental data with its clear exposition, will attract many a post-graduate whose "encephalization" was not arrested following his State Board. An adequate review would be possible only by Fulton himself.

An interesting manner of presenting the old concepts in order to contrast them with the new makes reading more fruitful for the clinician who recalls the teaching of not so long ago and has not followed the more recent advances. The older concepts register and, so to speak, make possible a readier understanding of the newer theories.

Special attention is given to primate forms because of their greater encephalization and hence more readily compared to man. Morphology is discussed in great detail as a necessary background for proper appreciation of function. Neuroanatomy and its newer developments are presented with clarity, aided by many line illustrations with controversial material added in foot notes.

The neurologist and the orthopedist, both especially concerned with cerebral birth injuries, will appreciate the chapter on "The Extension Reflexes". In this chapter evidence is given to prove the existence of a stretch reflex in extensor muscles and not in flexor muscles, with one exception, called the "pluck reflex". The extensor reflex, unlike the flexor, is primarily concerned in resisting the action of gravity and hence is considered a basic postural reflex. It can be sustained for two or three hours. The stretch reflex continues to increase as the tension is increased because more muscle fibers are brought into a state of tension. This recruitment of additional units accounts for the sustaining quality. When an extensor muscle contracts, its opposing flexor muscle relaxes. This is a basic pattern of spinal reflexes and illustrates the principle of reciprocal innervation. Fulton calls attention to the interesting phenomenon found in a paraplegic man, namely, that the Babinski response can be produced as easily by pricking or pinching the thigh. The stimulus which would produce pain in an intact man is the adequate stimulus par excellence. Spasticity is described as a state of abnormal exaggeration of the stretch reflexes, generally more marked in the extensors of the hind limb. Areas four and six, when both are removed, set up a state of spasticity. One differential sign that is suggested is the Babinski response. If only area 4, the motor area, is ablated, simple extension of the toes is seen. If the pre-

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motor area, area 6, is also destroyed, the toes extend slowly, separate and fan out. Forced grasping response is also present when both areas are involved and is absent if the motor area alone is affected.

The close association of experimental and clinical physiology is a delight to the reader. Here complex reactions are explained. The mechanisms of resting tremor, rigidity, athetosis and chorea are stated so clearly that everyone can grasp it. You must procure and read this stimulating work. As a source book it belongs on your work shelf and on mine.

If the electrocorticogram will actually record reactions of a single cortical neuron, then perhaps physiologists will soon be able to trace mental phenomena. To be able to trace a thought — what a fascinating prospect!

C. W. Goff



### FEMININE HYGIENE IN MARRIAGE

by A. F. Niemoeller, A.B., M.A., B.S.

155 pages	\$2.00
New York	Harvest House 1938

This little book, one of the series on the subject of sex by the same author, contains 155 pages, and 6 drawings from the magazine "Sexology". It is intended for the laity, but unlike many similar sounding titles, this book is really on the hygiene of marriage and not concerned with contraception. Menstruation and its disorders, the more common pathological conditions met in gynecology, venereal diseases, pregnancy and the change of life are all adequately discussed. Doubtless it will find a well deserved place amongst works of its kind and is worthy of perusal by the profession.

D. B. Beckwith



### SUPERFLUOUS HAIR AND ITS REMOVAL

by A. F. Niemoeller, A.B., M.A., B.S.

155 pages	\$2.00
New York	Harvest House 1938

In twenty-one chapters the author has ample opportunity to cover the subject specified in the title of this book. This is done in simple, non-technical language intended solely for the laymen. He emphasizes the advantages and disadvantages of the various methods commonly used for the removal of superfluous hair. The temporary removers of chemical and mechanical nature, such as depilatories, abrasives, shaving, tweezing, waxes and bleaching are thoroughly described. So also are the permanent means of removal by electrolysis, diathermy and roentgen ray.

In an excellent chapter the author warns of the dangers of Roentgen ray for the removal of unwanted hairs. As he states, the best modality advocated for permanent removal is electrolysis, (diathermy not finding much favor in this country). However, Niemoeller goes further than physicians would, when he recommends the use of elec-

trollysis by the patient in the home. As a matter of fact, the use of electrolysis in the home should be strongly condemned. For obvious reasons, whenever this modality is used, it should be in the hands of physicians or technicians under their direct supervision.

In other respects, this volume should be valuable to the laymen, not the least in that it exposes the false claims of some of the unscrupulous manufacturers in the cosmetic industry.

Harry Bailey



### SENATOR WAGNER INTRODUCES HEALTH PROGRAM LEGISLATION

On February 28 Senator Wagner of New York introduced in the Senate a bill for the carrying out of some of the phases of the National Health Program. In the proposed bill Senator Wagner offers a series of amendments to the Social Security Act calling for an expenditure of federal funds amounting to \$80,000,000 the first year with gradual increases over a ten year period for the purpose of establishing, expanding and improving state programs for "(1) child and maternal care; (2) general public health services and investigations; (3) construction of needed hospitals and health centers; (4) general programs of medical care, and (5) insurance against the loss of wages during periods of temporary disability." Senator Wagner said in an interview that it "should be clearly understood that the bill does not establish a system of health insurance or require the states to do so." Funds would be made available under this bill to "those localities and states which are in the greatest need of these services," the size of the grants being determined "on a variable matching basis, depending on the relative financial resources of the several states as determined by the per capita income of their inhabitants." It is not possible at this time to offer a complete analysis of the details of the proposed legislation. Obviously, it will be necessary for suitable committees of the Congress to give careful consideration to the proposals. While the sum announced — namely, \$80,000,000 annually — is not large as compared with an annual expenditure of \$850,000,000 ultimately proposed by the National Health Program, it represents nevertheless a considerable sum. Senators interested in an economy rather than a spending program have already announced opposition.—J. A. M. A., *March*, 4, 1939.




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nervousness, etc., are due to eye trouble or have their origin elsewhere. When glasses are necessary he can prescribe them exactly for the corrective or relieving effect that is required.

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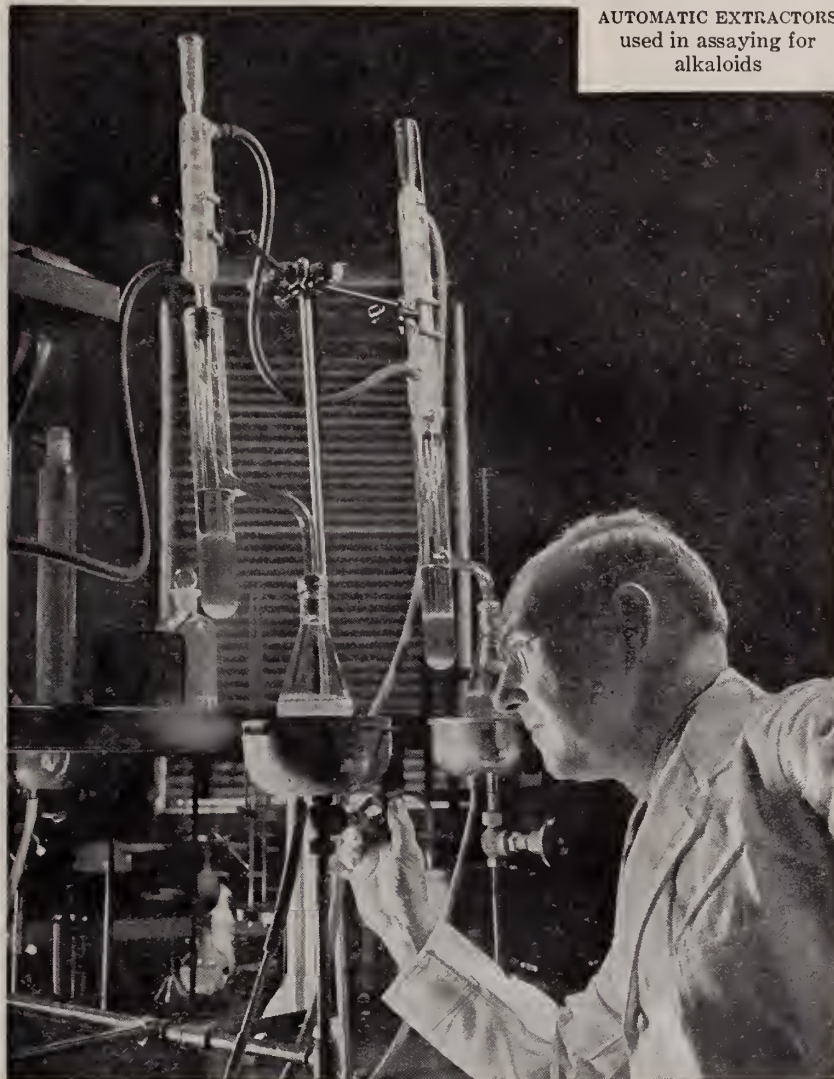
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A. Dextrin . . . .	50.0%
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Dextrose . . . .	16.0%
Sucrose . . . .	6.0%
Invert sugar . . . .	4.0%
Minerals . . . .	0.8%
(Dry Basis)	

2. Q. What are the properties of Karo?

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3. Q. What are the Karo equivalents?

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1 oz. wt. . . .	28 grams
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1 tablespoon . .	60 calcs.

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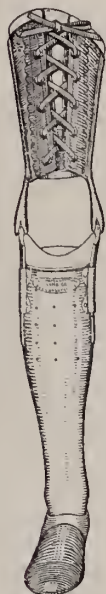


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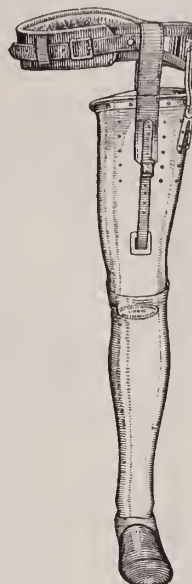
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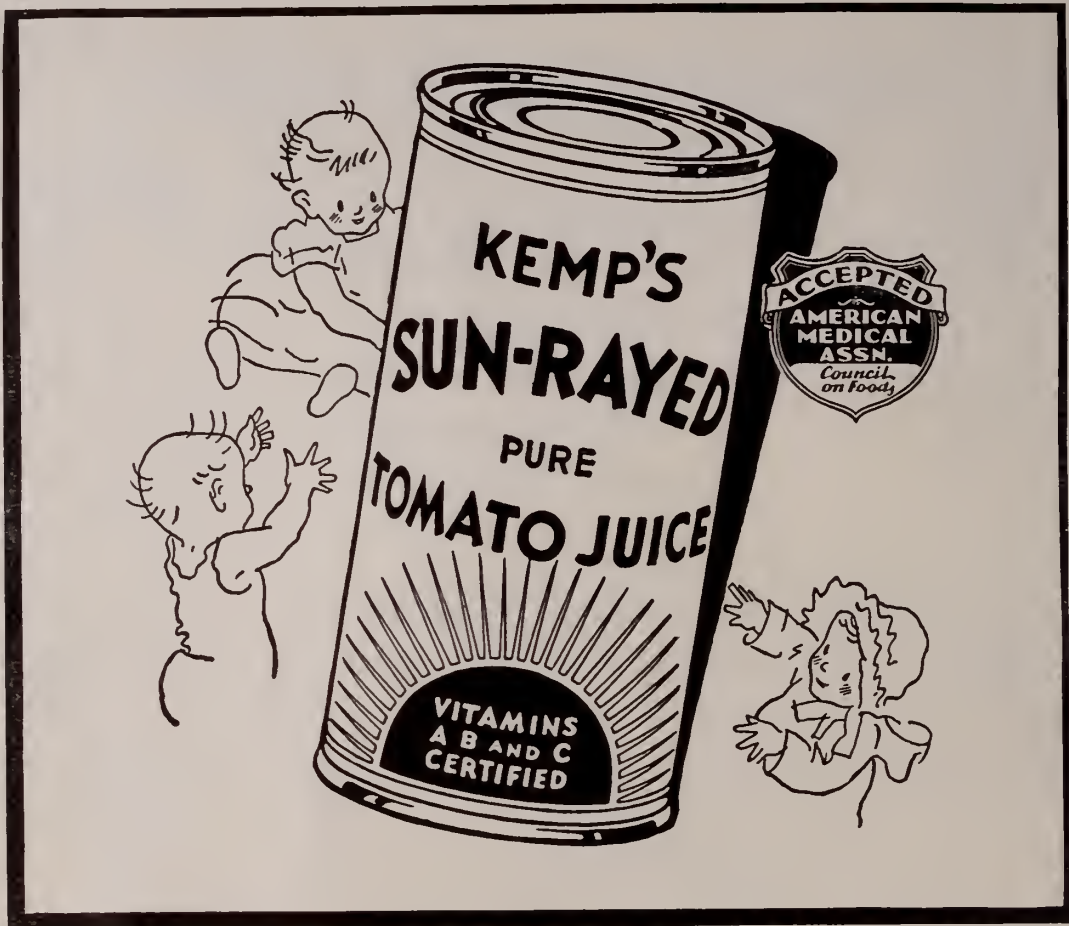
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## NOTE:

The gelatine used in this study was plain Knox Gelatine (U.S.P) which assays 85% protein and which should not be confused either with inferior grades of gelatine or with sugar-laden dessert powders, for these latter products will not achieve the desired effects. When you desire pure U.S.P. Gelatine, be sure to specify KNOX. Your hospital can get it on order.

**C**LINICAL research has recently demonstrated the effectiveness of utilizing plain Knox Gelatine (U.S.P.) in treatment of peptic ulcer. In a group of 40 patients studied, 36 (or 90%) were symptomatically improved; 28 of these (or 70%) experienced *immediate relief of all symptoms*. Other than dietary regulation which included frequent feedings of plain Knox Gelatine no medication was given except an occasional cathartic.

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This regime thus eliminates the "alkalosis hazard" attendant upon continued alkali therapy. In discussing the mode of action by which gelatine brings peptic ulcer relief, Windwer and Matzner\* speak of the acid-binding properties by which proteins can neutralize acids, and they state that the frequent gelatine feedings "apparently caused more prolonged neutralization of the gastric juice."

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Empty one envelope Knox Gelatine in a glass three-quarters filled with cold water or milk. Let gelatine settle to the bottom of the glass, then stir briskly and drink immediately. Take hourly between feedings for seven doses a day.

\*Windwer and Matzner, *Am. Jl. Dig. Dis.* 5:743, 1939.

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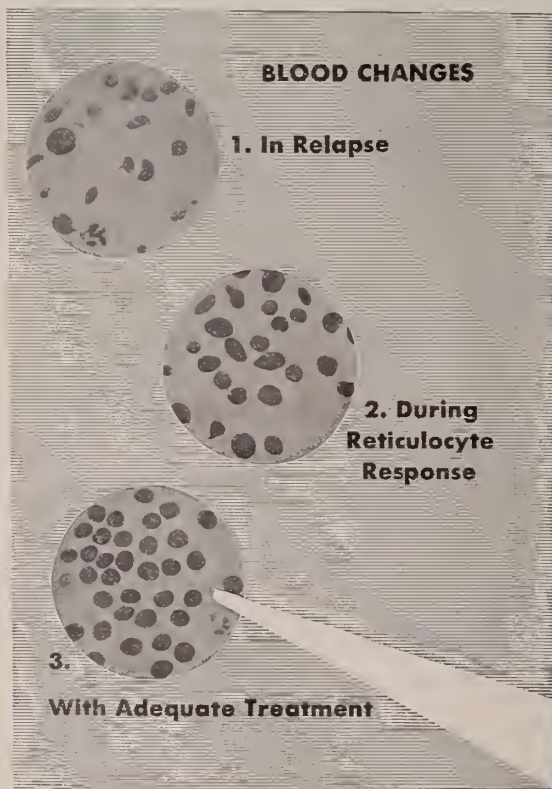


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Number of patients	Period of maintenance	Average Interval between injections	Average final R.B.C.
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10	26- 52	3.3	5.16
4	53-104	3.9	5.26
15	105-156	3.2	5.18
2	157-208	3.9	5.21

Reprinted from "The Use of Concentrated Liver Extracts in Pernicious Anemia" by William P. Murphy, M.D. and Isabel Howard, Jo. A.M.A., January 14, 1939, Vol. 112, pp. 106-110.

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# JOURNAL *of* The Connecticut State Medical Society

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VOL. III.

MAY, 1939

No. 5

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## . . . P R O G R A M . . .

### 147th Annual Meeting - - Connecticut State Medical Society

Hotel Taft, New Haven, May 25 - 26, 1939

Hugh B. Campbell, President

The program for this meeting has been arranged by the

#### **Program Committee**

Daniel C. Patterson, Chairman, Bridgeport

A. Nowell Creadick, New Haven

G. Gardiner Russell, Hartford

#### **Committee on Arrangements from The New Haven County Medical Association**

Charles E. Sanford, Chairman

William J. Dennehy

Ralph E. McDonnell

John C. Mendillo

Ralph N. Nichols

Samuel J. Silverberg

Harry L. Welch

#### TO THE EDITOR:

The program of the annual meeting on May 25th and 26th at the Hotel Taft, New Haven, has been arranged with the idea in mind of presenting practical everyday subjects that will be of interest particularly to the men in general practice,— at the same time those engaged in special work will find the papers and discussions of great value.

There has been an attempt to keep away from operative technique and the authors have dealt with their subjects from the physician's viewpoint, for instance:— in the symposium on Congenital Deformities, definite information will be given as to when and how these distressing conditions should be dealt with as well as an outline of the general care of the patient.

As the program is a full one and the papers must start and finish on time, it is earnestly requested that the members be prompt in attendance, and thus help to promote a smooth performance. We have been very fortunate in securing the distinguished guest speakers whose names appear on the program, and the committee is very appreciative of their friendly interest. Remember, the Scientific Session starts at 9:00 A.M., on May 25th, with Dr. Roy McClure, Chief Surgeon of the Henry Ford Hospital, Detroit, presenting his remarkable film on the "Treatment of Burns."

The Program Committee

## THURSDAY, MAY 25

Registration, Hotel Taft

Call to order by the President, Dr. Hugh B. Campbell

- 9:00 Welcome — Cole B. Gibson, President of the New Haven County Medical Association.  
9:00 Motion picture, "Modern Treatment of Burns — Reduction in Death Rate."  
Dr. Roy D. McClure, Detroit, Michigan.  
9:30 Treatment of Wounds.  
Dr. Arthur H. Bissell, Stamford.  
9:55 The Factor of Delay in the Recognition of Common Surgical Conditions.  
Dr. Edward J. Ottenheimer.  
10:20 Essentials in Fracture Treatment.  
Dr. J. Leonard Vickers, Greenwich.  
10:45 Summing-up Discussion.  
Dr. Arthur W. Allen, Boston.

## Intermission

- 11:30 The Problem of Cleft Lip and Cleft Palate.  
Dr. Claude C. Kelly, Hartford.  
11:45 Urogenital Deformities.  
Dr. Chris H. Neuswanger, Waterbury.  
12:00 Congenital Orthopedic Deformities.  
Dr. Arthur S. Griswold, Bridgeport.  
12:10 Management of Congenital Defects of the Nervous System.  
Dr. William J. German, New Haven.  
12:30 Summing-up Discussion.  
Dr. Thomas H. Lanman, Boston.

## Luncheon

## PROGRAM — SECTION MEETINGS

## Orthopedic Section — Parlor A

- 2:00 Business Meeting.  
2:20 The Connecticut Register for Crippled Children.  
Dr. Louis Spekter, Chief, Division of Crippled Children, State Department of Health.  
By invitation.  
2:40 Varieties of the Healing Process in Spinal Tuberculosis.  
Dr. Paul P. Swett, Hartford.  
3:00 An Approach to the Arthritis Problem.  
Dr. Denis S. O'Connor, New Haven.  
3:20 Legg-Perthes' Disease.  
Dr. Maurice M. Pike, Hartford.  
3:50 Scoliosis, A Rational Form of Treatment.  
Dr. Charles W. Goff, Hartford.  
4:10 The Rate of Restoration of Function in Knee Injuries.  
Dr. William S. Perham, New Haven.  
4:30 Herniation of Intervetebral Discs — Report of Eleven Cases.  
Dr. Ralph D. Padula, Norwalk.

(Continued on Page 214)

**McClure, Roy Donaldson**

A.B., Ohio State University, 1904; M.D., Johns Hopkins University, 1908; House Surgeon, New York Hospital, 1909-1911; Resident Surgeon, Johns Hopkins Hospital, 1912-1916; Major, Medical Corps, U. S. Army, 1918-1919; Surgeon, Henry Ford Hospital, Detroit, Michigan; author of numerous papers giving results of studies and experiments alone and with others; Member Editorial Board, Annals of Surgery, also American Journal of Surgery; Fellow, American College of Surgeons.

**Bissell, Addison H.**

Princeton, 1912; M.D., Cornell Medical College, 1916; Intern, New York Hospital House of Relief, 1916-1917; Medical Corps, U. S. Army, 1917-1919; Fellow in Surgery, Mayo Clinic, 1919-1920; Attending Surgeon, Thanksgiving Hospital, Cooperstown, N. Y., 1920-1927; Attending Surgeon and Chief of Surgical O.P.D., Stamford Hospital, Stamford, Connecticut.

**Ottenheimer, Edward**

M.D., University of Virginia, 1922; Member, American College of Surgeons and of New England Surgical Society; Surgeon-in-chief, Windham Community Memorial Hospital, Willimantic, Connecticut.



**Vickers, J. L.**

A.B., Johns Hopkins University, 1919; M.S., University of Wisconsin, 1921; M.D., Johns Hopkins University, 1924; Assistant and Instructor in Physiology, Johns Hopkins University, School of Medicine, 1922-1924, 1926-1927; Instructor in Physiology, University of Wisconsin, 1927-1928; Assistant in Surgery, Yale University, School of Medicine, 1925-1926, 1928-1929; Resident Surgeon, Children's Hospital of Michigan, 1929-1930; Assistant in Surgery, Columbia University, New York; Attending Clinical Surgeon, Bellevue Hospital, New York; Attending Surgeon, Greenwich Hospital, Greenwich, Conn.; Consultant in Orthopedics, Greenwich Municipal Hospital.

**Allen, Arthur W.**

M.D., Johns Hopkins University, 1913; Lecturer in Surgery, Harvard Medical School; Chief, East Surgical Service, Massachusetts General Hospital, Boston.

**Neuswanger, C. H.**

A.B., Colorado College; M.D., Harvard Medical School, 1923; M.S., Yale, 1925; engaged in medical research in the Aviation Corps in France during World War; Assistant Clinical Professor of Surgery, Yale University





**Fraser, John**

M. D., McGill University Faculty of Medicine, 1910; Professor of Obstetrics and Gynecology, McGill University; Director of Department of Gynecology and Obstetrics, Royal Victoria Hospital, Montreal; Member, American Gynecological Society; Member, Board of Regents, American College of Surgeons.

**Lanman, Thomas H.**

A.B., Harvard, 1912; M.D., Harvard Medical School, 1916; Intern, Massachusetts General Hospital, 1917-1918; First Lieutenant, Medical Corps, U. S. Army, 1918-1919; Associate in Urology, Peter Bent Brigham Hospital, 1920-1922; Visiting Surgeon, Children's Hospital, Boston; Assistant Professor of Surgery, Harvard Medical School; Fellow, American College of Surgeons.



**Thoms, Herbert**

M.D., Yale University School of Medicine, 1910; Associate Professor, Obstetrics and Gynecology, Yale University; Associate Obstetrician and Gynecologist, New Haven Hospital; Member Editorial Boards — Journal Connecticut State Medical Society, Yale Journal Biology and Medicine, Washington Institute of Medicine; Associate Editor, Davis' System of Obstetrics and Gynecology; author of several books.

## THURSDAY MAY 25,—SECTION MEETINGS—(Cont.)

**Connecticut Hospital Association Section — Ball Room.**

2:00 Business Meeting.

2:45 Staff Organization and Responsibility.

Dr. Samuel C. Harvey, New Haven.

Relationship between New England Hospital Association and the Connecticut State Hospital Association.

Mr. Warren F. Cook, Boston.

**Connecticut Occupational Therapy Society Section — Room 121.**

2:00 Occupational Therapy as Prescribed Treatment in the Municipal Hospitals in New York.

Miss Mary E. Merritt, New York.

Display in the corridor of the ball room

**Section on Proctology — Room 117.**

4:00 Ano-rectal Tuberculosis.

Dr. A. W. Martin Marino, Brooklyn, N. Y.

Discussion.

Dr. R. Glen Urquhart, Norwich.

**Section on Radiology — Room 128.**

4:00 Recent Advances in Radiologic Diagnosis.

Dr. Samuel A. Robins, Boston.

**American Society of Anesthetists Meeting with the Section on Anesthesia — Room 126.**

4:00 Blood Transfusions and a New Apparatus for their Administration.

Dr. Joseph Fine, Hartford.

Clinical Investigation of Circulatory Disturbances during Spinal Anesthesia.

Dr. E. A. Rovenstine, New York.

Pre-operative and Post-operative Care.

Dr. Soma Weiss, Cambridge.

**Conn. Branch American Association of Medical Social Workers — Room 125.**

4:00 What Determines the Function of Medical Social Service.

Miss Theodate Soule, New York.

Industrial Medicine Display in the corridor of the ball room

7:00 Annual dinner of the Society.

Hugh B. Campbell, presiding.

Presentation of visiting delegates.

Address, "Political Therapeutics."

Mr. Maurice S. Sherman, Editor, Hartford Courant.

## FRIDAY, MAY 26

Registration, Hotel Taft.

9:30 Final Meeting of the House of Delegates — Parlor A.

9:00 General Session.

Call to order.

9:00 Motion picture, "The Essentials of Pelvimetry."

Dr. Herbert Thoms, New Haven.

9:30 Rational Therapy.

Dr. Carl H. Wies, New London.

9:55 Vaccines of Value.

Dr. Sidney S. Chipman, Norwalk.

(Continued on Page 216)



**Wies, Carl Hendricks**

B.S., Massachusetts Institute of Technology, 1927; M.D., Yale University School of Medicine, 1932; Member of Visiting Staff, Lawrence and Memorial Hospital, New London, Conn.; Clinical Instructor in Medicine, Yale University.



C



C

**Parmelee, B. M.**

M.D., University of Vermont School of Medicine, 1918; Intern, Bridgeport Hospital, 1918-1919; Radiologist of Bridgeport, Danbury and New Milford Hospitals; Consultant in Radiation Therapy, Stamford Hospital, Stamford, Conn.

**Urquhart, Robert Glen**

M.D.C.M., McGill University Faculty of Medicine, 1924; Member of Staff, Uncas-on Thames Hospital, 1925 —; Surgeon-in-chief, Connecticut State Sanatoria, 1930 —; Consultant Thoracic Surgeon, St. Joseph's, W.W. Backus and Hartford Hospitals; served with Canadian Expeditionary Forces, 1917-1918; Fellow, American College of Surgeons.



C

## FRIDAY, MAY 26—(Cont.)

- 10:10 X-ray Fallacies.  
Dr. Berkeley M. Parmelee, Bridgeport.
- 10:30 The Apical Cavity in Pulmonary Tuberculosis.  
Dr. R. Glen Urquhart, Norwich.
- 10:40 Chemotherapy of Pneumonia.  
Dr. Francis G. Blake, New Haven.
- 11:00 Summing-up Discussion.  
Dr. Chester S. Keefer, Boston.

## Intermission

- 11:30 Treatment Procedures for Cancer of the Uterus Advised by The Connecticut Tumor Clinics.  
Dr. James R. Miller, Hartford.
- 12:00 Dysmenorrhea.  
Dr. Carl E. Johnson, New Haven.
- 12:30 Summary of Gynecological and Obstetrical Papers.  
Dr. John R. Fraser, Montreal, Canada.

## PRESIDENTS' LUNCHEON

- 1:30 Presentation of the Incoming President, Joseph I. Linde, New Haven, and the President-elect.  
Address of the Retiring President, Hugh B. Campbell, Norwich.

## PROGRAM — SECTION MEETINGS

**Section on Obstetrics — Ball Room.**

- 2:30 Subject to be announced.  
Dr. John R. Fraser, Montreal, Canada.
- 4:00 Music and cocktail hour at the home of Dr. Emerson L. Stone, 3 Bayberry Road, Hamden.  
Everyone is invited.
- 7:00 Section dinner at the Hotel Taft.  
"Recent Trends of Maternal Mortality in the United States."  
Dr. Edwin F. Daily, Washington, D. C.

**Hezekiah Beardsley Pediatric Club of Connecticut — Parlor A.**

- 2:30 Informal presentation of some pediatric problems.  
Dr. Louis Spekter, Hartford.  
Dr. Oliver L. Stringfield, Stamford.
- 4:00 Psychological Effects of Injury and Disease in Early Childhood.  
Dr. Bronson Crothers, Boston.

**Section on Eye, Ear, Nose and Throat — Room 128.**

- 4:00 The Use of Benzedrine in Refraction.  
Dr. S. Judd Beach, Portland, Maine.  
Therapeutics of the Ear, Nose and Throat.  
Dr. Frederick N. Sperry, New Haven.  
Tumors of the Larynx, Benign and Malignant — Diagnosis, Prognosis, and Treatment.  
(Moving pictures in color.)  
Dr. Gabriel Tucker, Philadelphia.
- 7:00 Section Dinner at the Hotel Taft.

**Section on Dermatology and Syphilology — Room 117.**

- 4:00 Occupational Dermatoses from the Viewpoint of the General Practitioner.  
Dr. John G. Downing, Boston.

(Continued on Page 218)



**Blake, Francis G.**

A.B., Dartmouth, 1908; M.D., Harvard Medical School, 1913. House Officer, Asst. Res. Phys. and Resident Physician, Peter Bent Brigham Hospital, 1913-16; Mosely Travelling Fellow, Harvard, 1916-17; U. S. Army Med. Corps, 1918-19; Hospital of the Rockefeller Institute, 1919-21; Professor of Medicine, Yale Medical School and Physician-in-Chief, New Haven Hospital, 1921-.

C

<sup>6/</sup>  
**Keefer, Chester F.**

M.D., Johns Hopkins University, 1922; formerly Instructor in Medicine, Johns Hopkins University and University of Chicago; Associate Professor of Medicine, Peiping Union Medical College, China; Associate Professor of Medicine, Harvard Medical School; Associate Physician, Thorndike Memorial Laboratory; Junior Visiting Physician, Boston City Hospital.



C



**Miller, James Raglan**

A.B., Yale, 1907; M.D., Johns Hopkins University, 1911; Post-graduate study, Munich, 1911, Freiburg, 1911-1913; Instructor of Clinical Obstetrics, Johns Hopkins University, 1914-1915; Medical Corps, U. S. Army, 1917-1919; Obstetrician and Gynecologist, Hartford Hospital; consultant to several hospitals in Connecticut; author of numerous professional articles; Licentiate, American Board of Obstetrics and Gynecology.

C



## FRIDAY, MAY 26—SECTION MEETINGS—(Cont.)

**Section on Neurology and Psychiatry — Room 121.**

4:00 Vitamin Deficiencies.

Dr. Edwin F. Gildea, New Haven.

Attitudes of Primiparae as Observed in the Pre-natal Clinic.

Dr. Lloyd J. Thompson, New Haven.

Hereditary Chorea in Colonial Connecticut.

Dr. Percy R. Vessie, New York.

**Connecticut Medical Examiners Section — Room 126.**

7:30 Subject to be announced.

Coroner Theodore E. Steiber, Fairfield.

**THE COMMERCIAL EXHIBIT**

**\*Lederle Laboratory.** Sulfapyridine and Allergens. The exhibit will feature "sulfapyridine"—serum's promising new chemical ally recommended in connection with serum therapy in the treatment of pneumococcal pneumonia.

**\*The Sun-Rayed Company.** Kemp's Sun-Rayed Pure Tomato Juice — the original and the best — never thin or watery. Approved by the American Medical Association. U. S. Government graded, made into juice by patented process, insuring high retention of Vitamins A and C. Pasteurized but not cooked.

**C. B. Fleet Company.** Phospho Soda Fleet. This exhibit will display literature explaining the uses of Phospho Soda Fleet.

**\*Commercial Casualty Insurance Company.** Mr. Arthur W. Eade, Insurance, will be present to answer inquiries and display a sample policy and questionnaires.

**Brock-Hall Dairy.** Softkurd Milk.

**\*E. L. Washburn & Company, Inc.** Latest type short wave equipment. Modern short wave therapy. Last minute office furniture with latest developments in medical accessories will be on display.

**\*D. G. Stoughton Company.** Anesthesia equipment, metabolizer, resuscitator, pneumothorax apparatus, dermator, latex catheter, drugs and biologicals. Surgeons, physicians and hospital supplies and equipment will be exhibited.

**\*Professional Equipment Company.** X-ray equipment, current physio-therapy apparatus advances in drug and intravenous therapy, furniture. Complete equipment and supplies for physicians, surgeons and hospitals will be shown.

**\*Smith, Klein & French Laboratories.** Benzedrine Sulphate. Information about "Benzedrine Inhaler", "Benzedrine Sulfate", "Benzedrine Solution" and other products may be obtained from the convenient literature dispenser.

**Holland-Rantos Company, Inc.** Contraceptive specialties. A motion picture demonstration of modern contraceptive technique will be featured together with Koromex diaphragm and jelly, the H.-R. Emulsion jelly and Koromex Diaphragm Introducer.

**Horlick Malted Milk Corporation.** Horlick's in powder and tablet form. Nourishing, digestible, appetizing — these are the three qualities for which HORLICK'S is famous. Discover the many uses, from infant feeding to old age. Note convenience of tablets in ulcer diets.

**\*Surgeons & Physicians Supply Co.** Complex short wave apparatus with cable, instruments. A new and interesting line of surgical instruments and supplies will be on display.

**Radium Chemical Company, Inc.** Radium and radon instruments. Demonstration of the handling and application of radium and radon, discussion of their requirements and leasing service.

**Johnson, Carl E.**

B.A., Stanford, 1922; M.D., Harvard Medical School, 1926; Associate Clinical Professor of Obstetrics and Gynecology, Yale University; Associate Attending Obstetrician and Gynecologist, New Haven Hospital; Attending Obstetrician and Gynecologist, Grace Hospital, New Haven, Connecticut.



**Chipman, Sidney S.**

Edinburgh University Medical School; M.D.C.M., McGill University Faculty of Medicine, 1928; Intern, Montreal General Hospital and Babies Hospital of City of New York; Member of Staffs of Norwalk Hospital, Norwalk, Conn., Babies Hospital, New York City and College of Physicians and Surgeons, Columbia University; Licentiate, American Board of Pediatrics, Fellow, American Academy of Pediatrics.



**W. J. German, M.D.**

**Griswold, Arthur S.** (No Picture)

A.B., Yale, 1918; M.D., Yale University School of Medicine, 1921; Intern, Bridgeport Hospital, 1921-1922; Associated with Dr. George W. Hawley in the practice of Orthopedic Surgery, 1922-1933; Attending Orthopedic Surgeon, Bridgeport Hospital, Bridgeport, Conn., 1933-.



**Acousticon.** Acousticons. Display of complete line of Acousticons provided for custom fitted hearing, correct assembly selected by Aurogauge.

**E. F. Mahady Company.** Physical therapy apparatus, Cutter prepared intravenous solutions in Saftiflask dispensers. New developments in surgical instruments and equipment will be displayed.

**Jones Metabolism Equipment Co.** Jones Motor-Basal. Display of the most modern metabolism apparatus on the market; it eliminates corrections for barometric pressure and room temperature and calculations.

**\*Mead Johnson & Company.** Mead's Infant Diet Materials. Three new Mead products will be on display, Mead's Thiamin Chloride Tablets, Mead's Cevitamic Acid Tablets, Mead's Nicotinic Acid Tablets.

**\*Philip Morris & Company.** Cigarettes. Demonstration of method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes.

**Eisele & Company.** Syringes, glassware, bandages. Display of hypodermic syringes, needles, glassware and clinical thermometers, also new linted elastic bandage and Luer style catheter point syringes.

**The Foregger Company, Inc.** Flow meter apparatus for anesthesia, helium and oxygen therapy equipment, resuscitation apparatus, intratracheal apparatus. The helium apparatus to be shown will be of interest not only to the hospital personnel and anesthetist but to the general practitioner as well, inasmuch as it is suitable for office and bedside use in treatment of acute asthmatic conditions.

**New Haven Dairy.** Golden Guernsey Vitamin D Milk. Mr. James E. Harper of the American Guernsey Cattle Club will be present to discuss the mineral values of Golden Guernsey Milk and Dr. Seegard of the Wisconsin Alumni Research Foundation, to discuss the value of homogenized Vitamin D milk.

**American Hospital Supply Co.** Baxter Blood Transfusion Set, Baxter Vacoliter, Coli-

Bactragen, Oxygenaire and Tomac Oxygen Insuflator. Display of automatic apparatus for continuous Wangenstein suction, Baxter Vacoliter, the same intravenous solution used exclusively by many teaching institutions and by over half of all American Hospitals.



### GROUP HOSPITALIZATION AND GROUP HEALTH SERVICE

The House of Delegates of the Michigan State Medical Society in special session approved the principles of voluntary group hospitalization and voluntary group medical service. It authorized the Council to proceed with the development of detailed plans consistent with the adopted principles.

Group Hospitalization, now in vogue in several states, allows a subscriber to purchase a given number of days of hospital services (exclusive of any professional services) for a moderate premium payment.

Group Medical Service, an entirely new procedure, enables a subscriber to purchase units of medical service, such units to include all the services rendered by Doctors of Medicine in all the Specialties.

The action of the House of Delegates calls upon The Council to develop its plans in cooperation with the Michigan Hospital Association, labor, industry, agriculture, religious and educational groups, community councils and other interested groups. It is recognized as a joint responsibility of both the community and the medical profession to bring adequate hospital and medical services within the reach of the low-income group of the community.

The medical profession is asked to recognize the importance of the adoption of the broad basic principles and to bear in mind that the development of the minute details is of lesser importance. In the development of details the interests of the patient and of the medical profession will at all times be guarded. Since The Council of the Michigan State Medical Society represents in a democratic manner the forty-two hundred members of the State Society, the latter's interests and views will be reflected in all deliberations. — *Jour. Mich. State Med. Soc.*, Feb. 1939.

\*Advertisers in the Journal.



# The Physician's Need for Income Protection

PAUL H. ROGERS\*  
Hartford, Conn.

Physicians have been consistent buyers of Accident and Health Insurance and for very good reason. There is perhaps no profession or business in which earnings are more directly dependent upon direct personal activity than that of the physician or surgeon. The owner of a business may usually expect it to go on for some time without his personal participation in it. Many salaried men may depend on a continuance of salary for some time during disability. A member of a legal firm may participate in the earnings of the firm during his temporary absence.

The physician sees his patients in his office, makes his calls, performs his operations, and earns substantially or, failing to do those things, he earns not at all. The problem of the physician is added to by the high overhead he must assume and of which he is not relieved by disability. The average physician has a fixed charge for his office, clerical help and perhaps nurse's service, that is a substantial item, and this overhead continues during disability. These expenses may not be offset with insurance. Accident and Health Companies have a rule that they will insure the major part of a man's earned income. This does not mean gross income; it means the net amount the applicant for insurance realizes out of his business or profession.

The physician who has gross earnings of \$9,000, office and clerical expenses of \$3,000, earns a net \$6,000. He may insure most of this \$6,000. In this case the companies would approve insurance of \$100 a week, or \$5,200 a year. The companies will not go beyond that for the reason that in case of long continuing or permanent disability the expenses of maintenance of an office would be discontinued. The physician, therefore, has a problem more pressing than the average man. Earnings cease wholly and immediately if the physician becomes disabled, substantial office expenses will go on at least temporarily, and the physician's

personal expenses will increase because of the expenses incident to his disability.

These facts are self-evident, generally understood by physicians, and are no doubt responsible for the extent to which physicians have been receptive to the subject of income protection when presented to them. There is the further fact that physicians are constantly being called upon for brief statements of fact concerning disability of their patients who carry Accident or Health Insurance, and physicians have been constantly reminded that their fees are in many cases paid more promptly because their patients have carried Accident or Health Insurance.

What income protection is essential to the physician? Perhaps first is weekly indemnity for disability resulting from accidents. The physician leads an active life. He is in and out of his car many times each day; he is on the street constantly, continually exposed to the traffic hazard, and payments of losses to physicians because of these hazards have been quite high. He is, of course, also exposed to the ordinary accidents about his home and we know that about one-third of all injuries occur in the home. For the physician there is no protection against this serious hazard except that offered by Accident Insurance. A policy that will immediately replace a substantial part of his income when the accident happens is of paramount importance. The better policies now available to physicians will pay throughout the entire period of disability resulting from an accident and in case of total and permanent disability the good policy will pay as long as the insured lives.

It would appear that next in order of importance in accident insurance is protection against the cost of medical, surgical, and hospital care which the physician, like everyone else, is exposed to. To meet this situation the leading companies have available blanket medical reimbursement coverage which pays all the

\*Superintendent, Accident and Liability Department, Aetna Life Insurance Co.

cost of hospital, medical, surgical, and nursing care, and as much as \$2,000 to \$4,000 of blanket medical expense insurance is available to the physician. With this coverage paying the bills, the income indemnity is left to replace the lost earnings without being dissipated by expenses incident to the hospital, medical, and surgical care.

Third in order, and perhaps hardly less important than the two coverages previously described, is indemnity for loss of life, limbs, or sight. Rarely is Life Insurance adequate, and it is quite likely to be inadequate in the case of the physician who suddenly loses his life as the result of an accident. The cost of insurance against loss of life resulting from accident is small as compared with the cost of ordinary Life Insurance, and the physician should supplement his Life Insurance with a substantial amount of insurance against this always threatening, always unforeseen hazard. Along with indemnity for loss of life the better policies of the leading companies now provide that if the insured shall lose the sight of both eyes, both hands, or both feet, he may elect to receive the weekly indemnity payable under the policy for the rest of his life.

Disability resulting from disease likewise immediately and wholly stops earnings. Perhaps the physician does more carefully than the average person protect himself against illness, but he is much more exposed to contagion. His profession requires his constant activity regardless of time or weather. Severe illness has its burdensome financial consequences.

As in Accident Insurance the first requirement is weekly indemnity. The physician should have weekly indemnity in a substantial amount. It should be in the same amount as his weekly indemnity Accident Insurance. The cost of weekly indemnity may be substantially reduced by a waiting period of two weeks. Health Policies of the better type commonly provide additional indemnity, usually half the amount of the weekly indemnity, while in the

hospital, and also a schedule of surgeon's fees providing payment of substantial amounts for most of the operations ordinarily performed.

Sickness Expense Policies have recently become available which provide quite liberally for the expenses incurred by illness. These policies pay a daily amount, usually \$5 to \$7 for hospital room, a similar amount for a nurse, a liberal schedule of operation fees and additional indemnity for physicians' fees. These Sickness Expense Policies may be purchased independently of, or in addition to, sickness income indemnity policies.

The problem of the individual physician may vary somewhat from the typical example that has been offered, but there is little variance in the need of physicians for substantial income insurance of the best type available and the physician will do well to have his insurance advisor consider carefully his own needs and make sure they are adequately met.



#### A LEG HOLDER FOR HOME OBSTETRICS

In the advertising columns for this issue your attention is called to a very practical adjunct to obstetrics in the home, the Russo Leg Holder. This leg holder is designed for attachment to a table only, weighs but 4½ lbs. per pair and measures 15½ inches closed and 30 inches extended. It serves as a valuable aid in forceps deliveries. Dr. Goodrich Schaffer, editor of one of the leading obstetrical journals in this country, comments very favorably on these leg holders and is introducing them to the Pacific Coast Society of Obstetrics and Gynecology as standard equipment for home obstetrics. Two large obstetrical clinics in this country have accepted this leg holder, The Chicago Maternity Center and The Central Free Dispensary of West Chicago. Although more and more the obstetrical work of Connecticut is being performed in the hospitals, there are still a certain number of deliveries performed each year in the homes of rural sections. We commend the Russo Leg Holder to the obstetrician who does home obstetrics.

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# Diagnosis and Incidence of Vitamin A Deficiencies\*

SELIG HECHT

Laboratory of Biophysics, Columbia University, New York

Visual function is intimately associated with vitamin A because this vitamin is a necessary element in the chemical events constituting the visual cycle. The chemical connection between vision and vitamin A has suggested the use of visual measurements for the detection of early stages in dietary avitaminosis-A, and several such studies have been made.

Some of these investigations have appeared to show that sub-clinical vitamin A deficiency occurs in as much as one-third or more of the population both in children and adults. However, these investigations have not been free of criticism. First, there have been inadequacies in apparatus and method; and second, there has been lacking an understanding of the physiological nature and meaning of the specific visual tests involved.

To lay an adequate basis for clinical and nutritional studies we investigated visual dark adaptation under standardized conditions chosen so as to report known and understandable elements of visual physiology. This involves a fixed light adaptation and the subsequent measurement of dark adaptation by a definite retinal area and with such lights that the behavior of the retinal cone system and that of the retinal rod system are separately shown, and the transition from cone function to rod function is clearly evident. A study of 110 individuals of university connections showed a reasonable spread of three characteristics selected as critically expressive of dark adaptation: (a) the final cone threshold, (b) the final rod threshold, and (c) the cone-rod transition time.

We consider the behavior of this population as normal for several reasons. First, there was no evidence from examination of their diets that those individuals with high light thresholds consumed less vitamin A than those individuals with low thresholds. Second, six subjects with the highest light thresholds were given 50,000 units

daily of supplementary vitamin A for 3 to 4 weeks; in five of them no change in threshold was produced, while the one individual who did decrease in threshold showed also a change in cone-rod transition time which probably indicates the involvement of a pathological factor. The third reason depends on the following controlled dietary experiment.

Four normal healthy young men were measured for dark adaptation during two weeks of their regular diet. They were then put on a diet which contained about 150 units of vitamin A per day, and their adaptation measured regularly. In all cases the cone and rod thresholds both began to rise at once. In a week the thresholds were above those commonly encountered in the normal population, and in two weeks the thresholds were above even the few extreme high values previously encountered. For the month of the duration of the nearly vitamin-A-free diet, the thresholds rose steadily, and would probably have continued to rise had the diet not been discontinued. During all this time the cone-rod transition time remained practically constant. The return to normal, even on a diet with a supplement of 50,000 daily units of vitamin A took nearly two months.

The flow of vitamin A from diet to retina may be interrupted not only by its removal from the diet, but by a pathological disturbance in its path. Such an instance is liver cirrhosis, and a study of several cases of alcoholic origin showed not only cone and rod thresholds well above those normally encountered, but a frequent increase in cone-rod transition time. Under vitamin A therapy these individuals were distinctly improved in that the thresholds and the cone-rod transition time returned to normal. Judging by the work of others, catarrhal jaundice and kidney stone also affect the cone-rod transition time.

Two things emerge from these studies. One is

*(Continued on Page 264)*

\*Abstract of paper presented at 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.



# Treatment of Peptic Ulcer and Its Complications\*

JOHN L. KANTOR, M.D.

New York City

To appraise the value of methods for treating gastric and duodenal ulcers is not an easy assignment. Among the many reasons for this difficulty are the following:

1. The course of "peptic" ulcer still remains to be discovered.
2. The course of ulcer varies greatly in different individuals and in the same individual in different attacks.
3. Strict controls are hard to secure.

New methods of treatment come into being either empirically, that is, because a procedure which is hit upon by accident actually works, or theoretically, that is, in the hope that the theory being correct, the desired result will follow. All theoretical methods stand or fall not only on the correctness of the reasoning behind them but obviously also on their effectiveness in actual practice. Moreover, even purely theoretical advantages may, on closer scrutiny, be counterbalanced by equally impressive theoretical disadvantages. It is generally assumed that hyperacidity is essential to ulcer production. Yet in gastric as opposed to duodenal ulcer, hyperacidity is the exception, not the rule; complete anacidity exists in one-tenth of the cases; in an additional quarter the acid figures are below average, that is, the acidity is already "controlled" by nature.

This raises the question of how much emphasis should be placed on the significance of the acid factor in etiology and on its elimination as the important aim in therapy?

## A. General Therapy.

Psychotherapy. Perhaps the outstanding recent development in general management of ulcer disease is the growing realization of the important role played by emotional factors. Psychic stress or trauma influence the initial attack and subsequent recurrence. Principles laid down by psychologists are as follows (Chappell, Stefano, Rogerson, and Pike);

1. Rest of a diseased part is an aid to rapid recovery.
2. Bodily rest and emotional hyperactivity are incompatible.
3. Ideas can give rise to marked emotional hyperactivity, usually, only after prolonged and intensive practice and review.
4. The forms of behavior through which emotional hyperactivity is learned and maintained are in all cases the same. They are: constant worry, discussion of difficulties, and attempts to control the emotional activity through effort.

In order to eliminate review of vicious emotional ideas by the patient, the following practical measures have been suggested: (1) Fear due to lack of understanding should be overcome by explaining the essential elements of physiologic psychology as above outlined. (2) The patient should be prohibited from discussing his troubles with anyone except his own physician. (3) Worry should be controlled by substituting some unemotional mental activity for that which is emotional. Each time that he finds himself dwelling on his worries, the patient should try to recall some pleasant experience. (4) Finally, the patient should be instructed to eliminate force and effort in attempting to control his mental processes. The exertion of "will power" is contra-indicated. To the average physician the last two procedures may appear difficult of execution.

The results of applying this psychological method have been reported by Chappell and his collaborators on 52 subjects who had been unsuccessfully treated by the usual medical procedures. The group was divided into an experimental section and a control section. Follow up after three years showed 36% of an experimental group completely symptom free. A better technic for handling the emotional factor in ulcer is probably in the making. It has not

\*Abstract of paper read before the Fairfield County Medical Association, Greenwich, January 10, 1939.

been decided yet whether the physician or the psychotherapist is to apply the psychotherapy.

**Diet.** Milk has been widely used to control the pains of ulcer but it may produce colonic symptoms where these were originally absent. Wheat and eggs as well as milk have been found by Gay to cause ulcer symptoms. A more liberal choice of articles of food is an important safeguard in ulcer management. The author uses tea and gruels, albumen fruit juice, or banana whip where milk is incompatible. Ulcer pains seem to be relieved in many cases as soon as milk is withdrawn from the diet. Meat should be given earlier, especially after severe hemorrhage where the protein and iron loss in the blood as well as the possible increased tissue destruction associated with presumably deeper ulcer erosion call for early and adequate replacement. According to the plan of Meulengracht (1931) that bleeding ulcers be treated by almost unrestricted liberal feeding, patients are fed without preliminary starvation a so-called full puree diet which calls for five meals a day and no restriction as to the amount eaten. The noon meal includes soups, meats, vegetables and fruits.

The trend of the last decade seems definitely toward liberalizing the ulcer diet. The rigid limitation in the choice of foods seems to be breaking down. The idiosyncrasies of individual patients are more respected.

The earlier feeding of meat may be regarded as a return to an older, and possibly better, procedure. The Meulengracht feeding after massive hemorrhage is a distinct liberalization, though it must be admitted that the preliminary period of starvation, formerly considered so indispensable, and particularly insisted upon after hemorrhage, has recently been observed more in the breach than in the practice.

**Physical Rest.** There has been no new development in regard to the universally recognized need for physical, as well as emotional, rest in the treatment of ulcer. We are still faced with the problem of securing adequate repose for people who must continue working. A modest suggestion in that direction is the writer's practice of insisting that such patients, instead of "staying up" to their usual bed-time, should retire immediately after the evening meal. In this way they will spend additional time in bed equivalent to one extra day per week, Sundays

and holidays serving as still further rest periods. This, or some similar simple plan, can also be adopted as a follow-up procedure following the more complete hospitalization rest in those who can afford it. Nothing in the past ten years has upset the old dictum that after two or three days of complete bed rest, and almost regardless of what else is or is not done for the patient, the ulcer symptoms disappear in the great majority of cases; and that persistence of symptoms should suggest the possibility of a wrong diagnosis. It is important to keep these basic facts constantly in mind in appraising the results of new treatments.

**Tobacco.** That tobacco stimulates the flow of gastric juice in some individuals was demonstrated experimentally by Gray in 1929. Recently much has been written concerning the influence of tobacco on the smaller vessels, particularly the end arteries. Clinically it has been observed that ulcer symptoms persist in some individuals no matter how treated just as long as the use of tobacco is permitted. Gray puts the figure at from 5 to 10 per cent of patients. Since skin tests have proved unreliable in picking out such susceptible patients, the writer's procedure has been to invite all ulcer victims who are smokers to undergo a voluntary period of experimental denicotinization involving the complete elimination of tobacco for a period of three to four weeks. The results determine the patient's future practice.

**Infections.** It has long been known that common infections such as head colds, tonsillitis, and dental root abscesses may initiate ulcer recurrences. The influence of head colds and of influenza has been especially studied by Einhorn (1930), and more recently by Crohn and Schwartzman (1937). The writer has the impression that tendency to hemorrhage may be enhanced by the presence of more or less cryptic infections, as in the tonsils, sinuses, and tooth sockets.

**B. Medicinal Therapy: Alkalies and Antacids.**

It has been definitely established that the use of large doses of alkalies can cause serious systemic mischief. It has also been suggested that alkalies are contraindicated in the anemias following hemorrhage. That large doses of adsorbents may impair food utilization also seems possible, and the burden of proof must rest on



the proponents of such medication. It is now seriously questioned whether alkalis, or to a lesser degree neutral antacids, are really essential to successful ulcer therapy. That is, of course, independent of the use of these drugs in the relatively small doses necessary for pain control. Unless one is committed to the hypothesis that complete acid neutralization is desirable to "heal the lesion" there really is no compelling reason for the use of either alkaline or neutral antacids in ulcer treatment. Most observers agree that sufficient rest and frequent feedings adequately control symptoms in the overwhelming majority of cases. Frick, Alvarez, Andresen, Bloch, Friedenwald and Morrison, and others including the reviewer, either use no antacids at all or else administer them in the smallest doses that are capable of controlling symptoms. It seems fair to say that this feeling has not weakened in the past decade despite all new developments. These conclusions are reached in spite of the widespread use of then eutral antacid, aluminum hydroxide, and the continuous drip method of treating ulcer.

#### C. Medicinal Therapy: Mucin.

In 1931, it was reported by Fogelson that ulcer symptoms were relieved by the administration of mucin prepared from the stomach of animals. It was assumed that this substance exerted a mechanical effect that protected the lesion while at the same time it combined with the free hydrochloric acid. These theoretical claims received some support from the experiments of Kim and Ivy on bile fistula dogs. Papers recommending the use of mucin as an aid in the ambulatory treatment of ulcer were published by Fogelson, Atkinson, and Clarence Brown and his collaborators in this country, and by Henning and Norpoth in Germany. The immediate effects obtained were the same as those secured by other methods. No follow-up observations of remote results have come to the reviewer's attention. It was not long before objections arose to the mucin treatment. Rivers, Vanzant and Essex, found a histamine-like substance in some samples, and Ralph C. Brown also found a "tremendous secretagogue effect." However, the most serious objection was the unappealing odor, taste, and consistency of the product which made it unacceptable to many patients (Smithies, Bloch and Rosenberg, Jordan). Somewhat similar experiences have been reported from the use

of the mucilaginous vegetable, okra (Meyer, Seidman, Necheles).

#### D. Medicinal Therapy: Injections.

Various non-protein substances have been used as a shock therapy, being injected intravenously or intramuscularly to produce a febrile reaction. Novoprotin, suspensions of killed bacteria, chiefly typhoid, Aolan, a mixture of foreign proteins with emetine and various lipoids known as Synodal, neutral pepsin, histidine known as Larostidin, a buffered solution of sodium citrate and sodium chloride, have all had their advocates.

There is no generally accepted scientific basis for this form of therapy. Initial improvement in symptoms does occur but not more often than after the older forms of treatment. If an occasional recurrent case becomes refractory to conservative treatment it may respond to injections, but as Sandweiss has shown, on still subsequent attacks it may resist further injections but resnd once more to conservative treatment. Since distilled water or saline injections also give comparable results in the hands of all observers except M. M. Benedict, it is difficult to escape the conclusion that all injection treatments depend, for their success, on purely psychic factors. Gaither and Rivers have come to similar conclusions. The reviewer agrees heartily with this viewpoint as well as with Fitzgibbon who says: "The injection of greatest value in the treatment of peptic ulcer is injection of common sense and conservatism, using hobbies and pet tricks when desired but accompanying them with the good old standardized and conservative methods that have proved to be of value for so many years."

#### Surgical Therapy

An excellent review of the recent literature is that of Fogelson. During recent years there has been no essential change in the surgical attitude toward the treatment of gastric ulcer. All gastric niches that do not disappear within a reasonable time on conservative management should be regarded as potentially malignant, and a resection of the stomach should be done as promptly as possible. On the other hand, it is in the surgical management of duodenal ulcers that significant developments have taken place. Here there seems to be a growing tendency among American surgeons to follow the continental procedure (Finsterer, v. Haberer) of



radical operation in every case which defies medical treatment. The procedure consists of a resection of the local lesion together with about three-fifths of the distal stomach. The advantages claimed for this operation are that it secures a permanent lowering of acidity, removes the site of the inflammatory process ("antroduodenitis") which is considered very important, and, best of all, is followed by the highest percentage (to date at least) of satisfactory results. In the hands of experienced surgeons, the mortality should not exceed 4.4 to 6.4 per cent, and may even be lower in selected cases. It is emphasized that the conservative operation of gastroenterostomy, instead of curing the patient, actually exposes him to the new danger of jejunal ulceration. Probably the best known proponents of the radical view in America are Berg, Lewisohn, Strauss, Hinton, Lahey, and the late John B. Deaver. On the other side, there are still representative surgeons who believe that routine resection carries too high a mortality, creates the possibility of anemia, and does not entirely free the patient from the danger of recurrent ulceration. In this country the Mayo group, The Johns Hopkins surgeons, and the Cleveland Clinic, are among those that represent this conservative viewpoint. Walters, Balfour, and Judd, have competently stated the case against radicalism.

Perhaps a brief statement of the reviewer's personal experience may be permissible. This summary is based on a series of 341 cases of duodenal ulcer, 76, or 23 per cent of whom had been operated on by various surgeons. Exactly one-half of the operations were done before, and one-half after the patients were first seen by the writer. Of the 38 cases operated on before being seen, there were fifteen operations for perforation and 18 gastroenterostomies; there was one resection and one enteroenterostomy for obstruction at the stoma; and there were 3 exploratory laparotomies. Of the 38 patients operated upon after being seen by the writer 20 had resections, the rest being divided between 12 gastroenterostomies and 6 closures of perforations. In other words, the frequency of resections seems definitely to be increasing. It is the writer's impression also, that the results of resections are better than those of other operations, always providing that the patient survives the operation.

Now as to this question of survival. In the

entire group only 19 patients were known to have died. Of these 19, ten died from causes not connected with the ulcer, and three from hemorrhage from the ulcer. Eight died following operation, but as four were perforations it would be fairer to say that there were only four operative deaths, three from resection or 15 per cent, and one from gastroenterostomy or 8 per cent. If one may draw any conclusion from so small a series, it would be this: Operation seems still to cause a few more deaths than does ulcer disease itself, and the mortality with resection is about twice as great as with the simpler operation of gastroenterostomy. Hence, in any given case, one must balance several variables, not the least important of which is the skill of the available surgeon.

#### F. Complications.

Hemorrhage. Bleeding occurred in 20% of my 341 duodenal ulcer cases, an incidence quite comparable to that of other writers (Eusterman and Balfour). The degree of hemorrhage varies greatly. Probably many small bleedings escape recognition entirely. The immediate management of this complication is well standardized and consists of bed rest, pulse and hemoglobin record, examination of the stools and vomitus, and close observation of the general condition of the patient, with blood typing in the serious cases.

The writer has practiced early feeding. He begins at once in pure melena cases, but postpones nourishment until the disappearance of nausea, vomiting, hiccup, and heartburn in patients with hematemesis. In his opinion, the Meulengracht diet is a real contribution to ulcer therapy.

Blood transfusion is justly regarded as an important method of therapy. The author's rule is to start transfusing as soon as the hemoglobin drops below 50 and earlier in some cases, and to continue the transfusions as long as they are indicated, that is, until the process of blood restoration can safely be left to the patient's own regenerative apparatus aided by the administration of iron. The writer does not agree with the late D. F. Jones that the beneficial effect of blood diminished with every transfusion. On the contrary, he has seen continuous drip blood transfusion, as recommended by Marriott and Kekwick, used with complete success.

As regards the indications for surgery in the presence of hemorrhage from ulcer, the writer's

position is very conservative. He does not agree with those surgeons such as Finsterer, Jones, and Pfeiffer, who advise that when operation is undertaken it should be done early, within 24 to 48 or 72 hours after the onset of bleeding, because he knows of no way of picking out those patients who will die if they are not operated on early. The only exception he has made, and still follows, is when the hemoglobin keeps dropping faster than the transfusions can restore it. In one such case successfully operated on there was an unsuspected small pyloric carcinoma in addition to the duodenal ulcer. By following the above plan, the author's mortality in 69 bleeding ulcers has been 3 or 4.3%. He admits his failure in these cases but believes that the mortality would have been much higher if the plan of early operation had been adopted.

After recovery from hemorrhage the author prefers to sit tight and watch what happens. If hemorrhage recurs and in increasing severity despite careful management including bed rest, a radical resection, performed during a free interval, seems the procedure of choice.

Obstruction. The treatment of obstruction due to ulcer, usually duodenal ulcer, is pretty well standardized. The medical treatment consists of dry diet, small meals, parenteral administration of fluids, and a course of gastric aspirations or lavages. In my experience, milk is especially contraindicated in obstructive cases. Recently Edward Hollander has reported success in the treatment of five cases of pylorospasm with 6 hour residue by oral digitalization. This procedure is based on the possibility that digitalis may act on the conduction system of the stomach in the same depressing manner as it does on the conduction fibers of the heart. Hollander administers the digitalis by the rapid method of Eggleston, calculating 2 minims of the tincture to the pound of body weight, and giving only three-quarters of the dose so estimated. In my opinion, further experience with this method is extremely desirable.

In cases which do not respond to medical measures, it is assumed that organic obstruction predominates over the spastic component. In such cases, surgical therapy is indicated. Most surgeons prefer a simple gastroenterostomy, though some of the more radical operators now perform a resection even in these cases. The

end results of surgical therapy for obstruction are good.

Perforation. Some few pinpoint perforations probably recover without surgical intervention. When, however, a perforation is definitely diagnosed, operation is indicated, the sooner the better. All statistics support this procedure.

### General Conclusions: Author's Present Attitude

What may one therefore conclude from a review of this sort? Perhaps the best answer would be to take a hypothetical case of ulcer and see just how one would proceed with its management in the present state of our ignorance. Obviously, no two physicians could be expected to think precisely alike, hence what follows should be regarded as a purely personal reaction. May I list the various items in their order of importance and in chronological sequence, as follows:

1. Emotional rest (peace of mind, equanimity).
2. Physical rest, including increased bed rest in every case, whether hospitalized or not.
3. Prevention or cure of infection (head colds, sore throats, sinusitis, tooth and gum infection, etc.)
4. Diet, liberal, bland and well balanced.
5. Avoidance of special irritants as tobacco and alcohol.
6. Medication, reduced to a minimum. Alkalies or antacids in smallest effective doses, if at all.
7. If the above measures fail, one should not immediately consider operation, much less try some newly devised remedy. It is much better at this point to revise the diagnosis. Perhaps it is the gall-bladder or some other condition that is really giving the symptoms.
8. If the diagnosis of ulcer is verified, try to tighten up on the basic therapy, including one formal bed rest treatment if at all possible.
9. Operation in general. In gastric ulcers that do not respond to medical management, resect at once! If the ulcer is duodenal, choose between gastroenterostomy for pyloric obstruction alone, and resection for all other cases.
10. In hemorrhage, sit tight. Transfuse if necessary, and feed liberally. Operate only for recurrent bleeding, and then in the interval stage if at all possible.
11. In obstruction, always begin with medi-



cal treatment, including gastric lavages, since the "obstruction" may be chiefly "spasm". When conservative treatment fails, surgical therapy can be relied upon to give good results.

### Summary

1. The appraisal of new methods of treating peptic ulcer is difficult because the cause of the disease is unknown and its course variable.

2. The outstanding development in the general management of ulcer is the growing appreciation of the importance of psychic factors.

3. The dietary treatment of ulcer has been liberalized. Milk is no longer regarded as absolutely essential; in fact, it is recognized as harmful in some cases. Meat is given earlier, especially in hemorrhage. In general, individual idiosyncrasies and preferences are more respected.

4. The danger of over-alkalinization has been recognized. Many competent physicians use alkalies and antacids very little or not at all.

5. The use of mucin seems to be diminishing.

6. Injection therapy seems to have no well-founded scientific basis. Its results are believed to be largely, if not entirely, psychic in nature.

7. There is no recent change in the surgical management of gastric ulcer. In duodenal ulcer, the trend is toward more radical therapy, based on subtotal gastric resection. The mortality is somewhat higher than that of the more conservative procedures but the results are better.

8. There is no convincing proof that early operation is the procedure of choice for hemorrhage. In bleeding cases expectant treatment, liberal feeding, and transfusions, repeated if necessary, still seem the best available measures. Operation should be reserved for recurrent hemorrhages and should be performed in the interval stage rather than during acute bleeding.

—☆☆—

### INFANT AND MATERNAL MORTALITY

The maternal mortality rate for 1937 was 49 per 10,000 live births, a drop of 14 per cent from the previous low rate of 57 established in 1936.

Causes of maternal mortality: United States, 1933-37.

	Maternal Mortality Rate				
	1933	1934	1935	1936	1937
Cause of death					
All causes . . . . .	61.9	59.3	58.2	56.8	48.9
Infection . . . . .	23.5	23.6	24.0	21.5	16.9
Due to abortion . . . .	9.8	10.2	10.1	8.4	6.9
Not due to abortion . .	13.7	13.4	13.9	13.1	10.0
Toxemias of pregnancy . . . . .	14.7	13.8	12.6	13.0	12.3
Hemorrhage . . . . .	6.4	6.5	6.4	6.5	6.0
All other causes . . . .	17.3	15.4	15.2	15.8	13.7
Nonseptic abortion . . .	3.1	2.6	2.8	3.2	2.6
Other causes . . . . .	14.2	12.8	12.4	12.6	11.1

Connecticut, with only 25 maternal deaths per 10,000 live births, had the lowest maternal death rate.

There were 1,413 fewer maternal deaths and 2,604 fewer infant deaths in 1937 than in 1936. As 58,547 more births were registered in 1937 than in 1936 these smaller numbers of deaths mean especially marked decrease in mortality. Both the infant and maternal mortality rates for 1937 are the lowest ever recorded for the United States.

The maternal mortality rates of 12 states were lower than any recorded in 1936. In 42 states and the District of Columbia the maternal mortality rate was lower in 1937 than in 1936, and the decrease was of statistical significance in 17 states.

The infant mortality rate for 1937 (54 per 1,000 live births) is 5 percent lower than the rate for 1936 (57). The infant mortality rates of 6 states were lower than any recorded in 1936. In 37 states and the District of Columbia the infant mortality rate was lower in 1937 than in 1936, and the decrease was of statistical significance in 26 of these States and the District of Columbia. — Tandy — *The Child*, Jan. 1939.

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# Surgical Relief of Intractable Pain\*

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Surgical procedures for relief of intractable pain may be advisable when the cause of the pain is unknown or cannot be eliminated. Such procedures should be based upon a definite knowledge of the anatomy and physiology of the neural pathways involved and should only be undertaken after careful attempts to determine the cause of pain.

Pain sensations arise in free or plexiform nerve endings and are conducted over poorly myelinated or non-myelinated fibers to the central nervous system. Physiologic characteristics of these impulses are: slow velocity, long after discharge, slow or absent adaptation and long chronaxie. Sensations of somatic pain enter the cerebro-spinal axis by way of the posterior roots and are conducted over the contra-lateral spinothalamic tract to the thalamus. "The thalamus is the center of awareness; concerned with the protective, affective and non-discriminative elements of sensation." (Stopford). Inhibition of the typical explosive thalamic responses is probably effected by certain cortico-thalamic fibers (Head). Sensations of visceral pain are conducted by autonomic fibers and may travel for a considerable distance over the sympathetic chain. They finally enter the spinal cord by way of the posterior (? and anterior) roots and reach the thalamus by way of the spinothalamic tracts. The exact mechanism of central pain is poorly understood. It may be present in certain lesions of the spinal cord, medulla and especially the thalamus. The pain pathways for some of the more common conditions are indicated in Table 1. Pain from visceral malignancy is placed under the "somatic" heading since interruption of the pain pathways in the spinal cord is the usual method for relief.

Where reasonable doubt exists concerning the neural pathways involved in a specific painful condition, diagnostic injections of novocain offer a valuable aid in deciding upon the appropriate surgical procedure. This method may be used in

TABLE I  
Pain Pathways

	Somatic	Autonomic
Face	Trigeminal Neuralgia Malignancy	Atypical Facial Neuralgia
Mouth	Glossopharyngeal Neuralgia Malignancy	
Extremities	Neuralgia, Malignancy	Vascular Disturbances
	Phantom Limb Causalgia	
Viscera	Malignancy	Angina Pectoris Pelvic Organs
Central	_____	_____

the peripheral nerves, sympathetic ganglia or in the form of spinal anesthesia. The effect thus obtained may be duplicated in a more permanent form by alcohol injection or section.

The various procedures for interruption of sensory impulses are shown in Table 2. Alcohol injection or section of peripheral nerves have the advantages of simplicity but the effect seldom lasts more than a year. In certain cases of trigeminal neuralgia or in painful malignancy of the face, alcohol injection is probably the method of choice. Well chosen peripheral nerve sections are extremely valuable in cases with painful vascular ulcers. An important secondary effect is the increased blood supply to the involved area. In the autonomic field, alcohol injections of the paravertebral sympathetic ganglia may be used in cases of painful vascular disturbances such as Raynaud's or Berger's diseases. However, when feasible, sympathectomy (Livingston) is usually a preferable procedure because of its more certain and lasting effects. For the pain of angina pectoris alcohol injection of the

TABLE 2  
Methods of Relief

Somatic	Autonomic
Alcohol Injection	Alcohol Injection
Peripheral Nerve Section	Nerve Section (Presacral)
Rhizotomy	Sympathectomy
	Chordotomy

\*Read before the 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.

upper thoracic sympathetic ganglia (White) appears at present to offer the best results. In cases of extensive pelvic malignancy section of the presacral plexus at the time of laparotomy may afford considerable relief from pain (Learmonth).

Section of the sensory roots (rhizotomy) (Foerster) has the disadvantage of producing a permanent loss of all forms of sensation in the area involved. For this reason the procedure should be limited to the trunk, face or mouth, since complete deafferentation of a limb is a serious functional handicap. In well established cases of trigeminal neuralgia differential section of the sensory roots (Frazier) is a most effective procedure. Pain in the glossopharyngeal field, whether neuralgic or due to malignancy, can be relieved only by intracranial section of the glossopharyngeal nerve (Bailey).

Of all the surgical methods of relieving pain in areas other than the head and neck, chordotomy (Frazier and Spiller) has the broadest scope of usefulness and is unique in its selectivity for pain and temperature sense. The operation consists in exposure of the spinal cord well above the upper level of pain, rotation of the cord by means of the dentate ligament and section of the contralateral anterolateral column. Temporary urinary retention and occasionally transient weakness of the lower extremities are the only common complications. Analysis of 20 consecutive cases of chordotomy is shown in Table 3. There were no deaths in this series, directly or indirectly referable to the operation.

TABLE 3  
Chordotomy  
(20 Consecutive Cases)

	Total	Pain		Re-	Im-
		Bilat-	Unilat-		
		eral	eral	lieved	proved
Carcinoma or Sarcoma	8	6	2	4	4
Tabes with Pain	2	1	1	2	
Painful Paralysis*	5	5		5	
Painful Parkinson's Disease	2	1	1	1	1
Neuralgia or Causalgia	2		2	1	1
Spinal Cord Tumor with Pain	1	1		1	
	—	—	—	—	—
Total	20	14	6	14	6

\*Paralysis followed unsuccessful intrathecal alcohol injection in 2 cases.

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THE WAGNER BILL

With all due respect to the senior Senator from New York, we would characterize the Wagner Health bill as extremely *amateurish* did we not suspect that this veteran political strategist has purposely drawn it so vaguely that its passage through Congress would encounter the least amount of oppositional friction in its passage toward enactment. The program seems to be: meet opposition with vagueness, let decisions be made later. *Après moi, le deluge!*

The public concern for the health of the people is entitled to more than a good piece of political strategy in a health bill. The profession which will have to work under the bill, the governmental agencies which plan the measures and procedures under its permissive clauses, and the taxpaying public which will foot the bills to pay for it — all deserve a *precisely drawn bill*, so that all will know beforehand just what is being proposed, what it will deliver, who sits at the controls, and what it is going to cost.

It seems to us that it should be realized that now is not the time to write another blank check on the Treasury to be filled in, at will, by lay experimenters in health measures for the general public. — *Edit., N. Y. Jour. Med., March 15, 1939.*



## Coccygodynia\*

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Coccygodynia is a painful condition of the tissues in the sacro-coccygeal-perineal region. The numerous types of therapy which have been advocated in the past for this condition reflect the confusion of ideas as to the pathology involved. The surgeon has thought of trauma, fracture, or displacement as the casual factor, and has treated his patients with manipulation, rest, or finally with excision of the coccyx with only partial success. Many cases have been cured by operation, and almost as many have not been cured. The psychiatrist has thought of coccygodynia as a type of neurosis similar to vaginismus and has refrained from local treatment and given psycho-therapy. The neurologist has thought of the disease as a neuritis of the coccygeal plexus, a nerve pinch or involvement of the coccygeal glomus. One of the best series of cases was published last year by Waters, who considers most of his cases neuritis of the coccygeal plexus and injects novocaine or alcohol. Forty-one of fifty-three of his patients were cured.

The most recent concept of the disease is that it is a tonic spasm of the muscles in the area of pain, with occasional involvement of the nerves by spreading inflammation or by pinching.

A finger inserted into the rectum first feels the tip of the coccyx and its anterior surface, and on either side the soft fibers of the levator ani muscle. Next the sacro-spinous ligament, and next the firm belly of the coccygeus inserting into the ischeal spine are felt, and still higher up and not so easily palpated is the pyriformis, which leaves the pelvis and inserts into the greater trochanter of the femur. The sciatic nerve emerges from the pelvis just below the pyriformis, the superior gluteal above it. The pudendal nerve is formed at the upper border of the pyriformis and emerges behind it.

All of the twenty-three patients that I have seen with this disease in the past year have had

tenderness and spasm in these muscles, usually on one side, occasionally on both, the coccygeus being the most prominently involved. When the exploring finger touches these muscles, the patient usually states that there is her pain. Sometimes the coccyx itself is not painful at all. Several patients in this series had pain over nerve distribution, usually the sciatic. One, a nurse, had sciatic pain on bending forward. One patient, a bookkeeper, had pain over the pudendal distribution. After treatment, this patient lost the muscle tenderness but still had pain in the vulva and is counted a failure. There were no men in this series.

The clinical picture of coccygodynia is not always simple, but usually the complaint is the same; i.e., pain on sitting. The mildest complaint only of a hard chair, the worst of the softest bed. The pain is usually relieved if the patient lies down, but may not be. There may be discomfort on walking, bending, or defecation. One patient complained of pain deep in the vagina, and the diagnosis would not have been made except for the rectal examination which revealed the tender muscles. This patient was cured in two treatments. There was no history of trauma, as from a fall, in any of this series; it followed childbirth in the majority. The onset was insidious in several. A few of the patients were bookkeepers and stenographers and it seems their constant sitting, whether it was an etiological factor or not, certainly aggravated and prolonged the condition.

The cases that I have seen responded promptly, with the one exception noted, to massage of the affected muscles as advocated by Thiele. Treatments were given every two or three days. Pain on sitting was relieved promptly, and muscle tenderness later. Treatments were continued until the muscles were soft and painless. An average of four treatments per patient was

*(Continued on Page 259)*

\*Read before the 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22 1938.



# Active Immunization Against Tetanus\*

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Good surgical practice has demanded that patients who have received injuries that are apt to be contaminated with tetanus organisms be given tetanus antitoxin for prophylaxis. This practice has reduced the incidence of tetanus tremendously.

The necessity of repeated injections of antitoxin in certain groups in hazardous occupations such as certain classes of railroad workers, agriculturists, those in military service, and others, is apparent. Many children, also, several times over a period of years receive injuries which require tetanus antitoxin.

Hypersensitivity to horse serum produced either by the administration of a previous dose of horse serum or by other means is common. All of you are familiar with the allergic reactions, many of them very severe, which so frequently accompany the administration of tetanus antitoxin. To obviate the possibility of these reactions and to produce an active immunity, which of course is more permanent, the use of toxoid has been carefully investigated.

Following the work of Ramon<sup>1</sup> and others, who developed the method of using the detoxified toxin for producing active immunity for diphtheria, application of the same principle was made in active immunization for tetanus.

After preliminary investigations by many workers of the immunizing action of toxoid in guinea pigs, studies were directed to the application of the antigenic agents in human beings. It was found that the antitoxic titer of human blood could be raised to sufficient levels for protection against the disease, although the response varied greatly in different individuals.

Later it was shown that the antigenic value of toxoid was increased by the addition of potassium aluminum sulphate, (the so-called alum precipitated toxoid)<sup>2</sup> to the extent that the amount of anti-toxin formed after the administration of two doses was greater than after three doses of plain toxoid.

To be effective this immunity must be equivalent to the immunity furnished by the usual prophylactic dose of antitoxin. In order to raise the titer of the blood to this level it has been found necessary to give two doses of alum precipitated toxoid with a rather long interval between doses, two months being the usual length of the interval.

The duration of the protective level of the immunity is variable, probably reaching the peak in three to six months after the second dose. In some individuals the protective level lasts over two years, while in others it lasts less than three months<sup>3</sup>.

It has, however, been observed that after the titer of the blood has dropped, a third dose given at the time of injury or at fixed intervals to those in hazardous callings, will raise the antitoxin level back to the point of protection very rapidly, that is, a few days, and before the usual incubation period of the disease, thus affording ample protection. Therefore, a person who has been given two doses of tetanus toxoid should not receive tetanus antitoxin but an additional dose of toxoid if the occasion arises. This third dose is absolutely necessary on account of the variation in response and to the lack of an easy test to determine the protective level of the blood; otherwise, as Gold<sup>3</sup> states, a false sense of security may result. He also states that the time required to raise the antitoxin to a protective level following reinjection also must be carefully studied.

From a review of the literature it is evident that this method of protection is of value and could advantageously be substituted for the usual method of protection at time of injury<sup>4</sup>.

The uncertainty of the antitoxin titer after immunization is the only drawback and, as Abt states, he would still prefer the use of tetanus antitoxin for immediate passive immunization in cases of injury in which it is deemed necessary<sup>5</sup>. McBryde, on the other hand, states that

\*Presented at 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.

this method is of special value in hyperallergic children and states that the usual dose followed by a third at time of injury is sufficient to protect the child. He states that this third dose would raise the serum antitoxin to the level reached on injection of 1500 units of antitoxin<sup>6</sup>.

Various authors advise different doses. The report of the Committee on Immunization of the American Academy of Pediatrics<sup>7</sup> recommends three doses of 0.5 c.c. — 1.0 c.c. and 1.0 c.c. at weekly intervals<sup>3</sup> while others recommend two 1.0 c.c. doses at an interval of two to three months. Some authors feel that two 0.5 c.c. injections is a sufficient dosage.

Recently a combined tetanus and diphtheria toxoid has been marketed and at least theoretically is reasonable, although literature on this combination is meager.

In conclusion, therefore, it can be said that:

(1) In certain selected groups of workers and in hyperallergic individuals, the use of tetanus toxoid for active immunization is advisable.

(2) After a certain period following the second dose, probably six months, if an injury is received and immunization is deemed necessary, a third dose of toxoid should be given to raise the protective level of the blood.

(3) In the event of an injury, received either between the first two doses or shortly after the second dose, and immunization is necessary, the regular prophylactic dose of tetanus antitoxin should be given.

(4) Tetanus toxoid should never be given for treatment of the disease.

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#### AN EXPERIMENT IN MEDICINE

The Chicago Tribune has announced the appointment of a medical counsellor for its large group of employees. The activities of the counsellor are to be under the control of the Dearborn Mutual Benefit Association, the official organization of Tribune employees. This is the first set-up of this sort that has come to our notice, and its operation will be watched with much interest by the medical profession.

It is announced that the physician in charge will not engage in the practice of medicine; rather will it be his duty to advise those employees who come to him for suggestions regarding medical care. The expense of the department will be borne by the Tribune.

For some time, it is said, the mutual welfare department of this newspaper has noted that numerous employees have been somewhat perplexed when they or their immediate families become ill, many of them not knowing where to seek competent medical attention. One of the duties of the physician in charge will be to see that the employee is referred to a capable physician. — *Ind. State Med. Jour. Feb. 1939.*



#### ROENTGEN THERAPY FOR INFLAMMATORY LESIONS

Clinical and experimental evidence shows that inflammatory lesions respond to roentgen treatment in proportion to the leukocytic infiltration, and that irradiation acts primarily by destroying a proportion of the infiltrating cells. It may not seem logical at first thought, to destroy the leukocytes which are poured in to wall off and limit the spread of the inflammatory process. On the other hand, their destruction rapidly renders more available the protective substances they contain for defense against the noxious agent. As a rule, the greater the degree of leukocytic infiltration of the tissues the quicker and more definite is the benefit from roentgen treatment. The poor results obtained in the treatment of some forms of inflammation are best explained by the small amount of leukocytic infiltration in the lesions in such cases, and in the treatment of chronic inflammation by an excessive amount of connective tissue.

—Leddy— *Arch. Phys. Ther., Feb. 1939*



# Congenital Aplasia of the Kidney and Hypoplasia of the Spleen: Case Report

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MAURICE R. MOORE, B.A., M.D., C.M.

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Baby Girl, E.S., born on June 29, 1938 and died on June 30, 1938 of Congenital Anomalies.

The mother was a 25 year old primipara who has been subject to very severe diabetes for fourteen years. She has had so many attacks of diabetic coma that she cannot tell the number.

Spontaneous labor began thirty-three days before the expected date of confinement and progressed satisfactorily until cervical dilatation was complete. A mid forceps delivery was done for right transverse arrest. Although a deep episiotomy was done, the vaginal canal was so narrow as to offer considerable resistance to delivery. After the delivery of head, the extraction of the body was accomplished with considerable difficulty because it was of unusually large relative size, appearing puffy. The baby breathed spontaneously. There was a marked caput. There was progressively less respiratory activity until the baby became markedly cyanosed all over. Mouth to mouth insufflation was used to start inspiration anew. Thereafter, the baby cried satisfactorily and color improved markedly for a short time, when color became worse and worse, so that oxygen and carbon dioxide were given with notable improvement. About twelve hours after birth, oxygen was started and continued until death occurred about eleven hours later. During life the baby was not observed to void.

Post Mortem Examination — The body weighed 2710 grams. The tissues of the feet, to a marked degree, and the body generally, appeared edematous. There was a large caput succedaneum over the parietal and occipital

regions. Extensive lacerations with interstitial hemorrhages of the tentorium cerebelli were found on the right side. There was moderate interstitial hemorrhage of the left side of the tentorium cerebelli. The right lung weighed 22 grams and the left 20 grams. Both sank when placed in water, but showed aeration of the lung margins. The heart weighed 20 grams, thymus 15 grams, liver 120 grams, all appeared normal. The spleen was represented by a mass of tissue which measured approximately  $1\frac{1}{2} \times 1$  cm. It was firm and was found to have a relative increase of fibrous stroma and a loss of the normal architecture. Careful search was made grossly and microscopically without finding any tissues recognized as kidney structures. Ureters were seen to take their origin in a tuft of tissue in the region of the lumbar vertebrae and pass to what appeared to be a normally constructed bladder. Uterus, tubes and ovaries were normal in appearance.

The difficulty in delivery of the shoulders may be attributed to the edema of the trunk and is believed to have occasioned the damage to the tentorium cerebelli which was the immediate cause of death. This edema of the body is apparently secondary to the congenital absence of the kidneys.

## Summary

1. Kidney structures were entirely absent.
2. Spleen was markedly hypoplastic.
3. The edema of the body was due to aplasia of the kidneys.
4. The lacerations of the tentorium cerebelli were extensive and terminated life.



# Pelvirectal Abscess and Retroperitoneal Cellulitis

## (Report of Three Cases)

KENNETH W. THOMPSON, M.D. and J. E. DUNPHY, M.D.

The fatal termination of a case of ischiorectal or perirectal abscess is occasionally caused by a complication sometimes called pelvirectal abscess, which is an extension of the infection above the pelvic diaphragm in the retroperitoneal tissues. At times this infection is not localized as an abscess but as a rapidly spreading cellulitis which extensively invades the retroperitoneal spaces. Although such cases are rare, and seldom are mentioned in surgical texts, there are probably several on record in every large clinic. The prompt recognition and early drainage of this retroperitoneal infection may be a life-saving measure. Two cases with this type of retro-peritoneal infection seen by the author and one other obtained from the records of the Peter Bent Brigham Hospital illustrate the course and treatment of this disorder, and as the subject of the present report they will serve to renew discussion of this serious condition.

The first case of pelvirectal abscess observed by the author is summarized as follows:

S.M., a Russian tailor, 48 years of age, admitted August 21, 1932 because of increasing pain in the anus for eight days. He consulted his physician five days prior to admission, and suppositories were prescribed. The patient stayed in bed, had fever and chills. On the day of admission he could not void and had to be catheterized.

**Examination** showed a very sick man, whose perineum was quite swollen and tender. The infection appeared more acute anterior to the anus, but there was no definite localization of the process. The abdomen was quite obese and markedly distended, with no tenderness. The temperature by mouth was 101°, the pulse rate 90, respirations 20, leucocyte count 14,000 per cu.mm.

**Course:** Poultices were applied to the perineum in an attempt to localize the infection. On the following morning no definite localization had occurred. In the early afternoon he was much more toxic; the abdomen was quite tender but not spastic; he appeared to have had a sudden rapid spread of infection. The perineum was incised widely on both sides of the anus, and from a fairly deep level, beneath edematous tissue, much thin foul pus and gas escaped. The patient was given 0.45 gm. of neoars-

phenamine intravenously in order to combat what was considered to be a *B. coli* septicemia, but the patient failed rapidly and died sixty hours after admission. He had been sick for only ten days.

**Autopsy** showed that the infection, starting near the anus, had caused necrosis of the levator ani muscle, had advanced upward behind the symphysis, thence to diffuse into the retroperitoneal and properitoneal areas of the pelvis, and had extended into the right paravertebral gutter as far as the liver. The peritoneum everywhere was intact. The fluid was thin, brown, and very foul, containing a mixed group of organisms without *B. Welchii*. The tissues affected contained gas. The heart-blood contained *B. coli communis*. In addition to the retroperitoneal infection described there was some infiltration anteriorly on the scrotum, and this had advanced 5 cm. above the symphysis by way of the reflections of the fascia of Colles. The scrotum and tunics of the cord were only slightly involved.

These autopsy findings were interpreted to indicate that the perineum should have been drained much earlier without waiting for better localization, and that at the first convincing sign of abdominal involvement, the abdominal wall and retroperitoneal spaces should also have been drained. These facts were vividly recalled when the following case came under our observation:

J.G., a married Italian shoemaker, 43 years of age, was admitted September 12, 1934, complaining for four days of increasing pain near the anus.

**Examination** showed a pale, pasty, fairly obese man who had an extensive ischiorectal abscess on the left side of the anus. The abdomen was obese, relaxed, not tender. There was no urinary difficulty, and the bladder was not enlarged. On admission the temperature by mouth was 102°, pulse rate 120, respirations 20, and the white blood cell count was 17,000 per cu.mm.

**Course:** Soon after admission the abscess was drained widely with novocaine anesthesia. Much thin, foul pus was obtained, and numerous dissecting tracts were opened.

During the two succeeding days, in spite of what appeared to be adequate drainage of the perineum, the patient became sicker, looked more toxic, and perspired profusely. He developed frequency and difficulty of urination, but there was no residual urine in the bladder. Never was edema or tenderness of the scrotum present.

On the second post-operative day, in the lower abdomen there appeared tenderness which increased on the left side, and this was accompanied by distention which became more and more troublesome during the day. Hot stupes gave no relief. In the evening the temperature was 103°, pulse rate 120, respirations 24, and the white blood cell count was 20,000 per cu.mm. Examination of the urine was negative. The markedly distended abdomen was deeply tender from the pubis to the iliac crests, more on the left. There was no spasm. Palpation of the inguinal rings showed marked tenderness of the region of the internal ring on the left. The patient was subjected to an exploratory tap in the left lower quadrant. Very foul, thin, brown pus was withdrawn from a level just beneath the posterior rectus sheath. Immediate operation for drainage was advised.

Under local novocaine anesthesia a muscle-splitting oblique incision 10 centimeters long was made in the left lower quadrant. Nothing abnormal was noted until the properitoneal space was entered, and then immediately a flow of very foul, thin pus was obtained. After walling off the field completely in an area of what appeared to be uninvolved fat, a small incision was made in the peritoneum; no evidence of infection was seen. This incision was closed carefully with catgut. The peritoneum was then pushed medially and the retroperitoneal and properitoneal spaces as extensively as possible were explored, freely draining many loculi of pus. Little pus came downward from the loin but a considerable amount trickled upward from the region of the bladder and pubic arch. A counter incision was made above the pubis in order to secure better drainage. No pus was found to the right of the midline. Dakin's tubes were inserted.

On the following day the patient was better and much necrotic material and pus drained from the wound, which was irrigated with Dakin's fluid. The patient had a hectic fever which gradually subsided after the 40th day, and the temperature was normal after the 57th hospital day. No further foci of undrained pus could be located to account for the prolonged fever. The final explanation appeared to be that such extensive necrosis in fat required time for lysis and healing.

Evidence in favor of an origin other than ischiorectal infection could not be obtained, since roentgenological and other studies showed no evidence of diverticulosis, osteomyelitis, or renal disease. The patient was discharged from the hospital after 62 days, when the perineal wounds had completely healed; but the abdominal tracts continued to drain a small amount of pus. He felt weak, but had no other complaints.

Four months later in the follow-up clinic it was noted that there was a small fistula in ano which had been alternately opening and closing on the left in the old scar. The mucosal opening was between the sphincters on the left anteriorly. The other wounds had healed well. The patient was advised to have the fistula operated upon.

A search in the records of the hospital for similar infections revealed only one other instance, which is summarized as follows:

W.H.H., an unmarried Irish laborer, 26 years of age, was admitted August 9, 1917 because he could not void. Two weeks prior to admission he began to have chills,

fever and profuse night sweats. One week later he began to have difficulty voiding, with pain, frequency, and urgency, progressing in 24 hours to retention requiring catheterization. All these symptoms were marked until admission to the hospital.

**Examination** showed a sick young man with slight distension of the lower abdomen, which was tender with voluntary spasm. There was moderate costovertebral tenderness on both sides. The temperature by mouth was 105.4°, pulse rate 132, respirations 28, and the polymorphonuclear leucocyte count was 19,000. Many pus cells were found in the urine, but cystoscopic examination failed to show evidence of pus coming from the kidneys.

**Course:** In 20 days no satisfactory diagnosis was made beyond infection of unknown site, and because his neck had been stiff for four or five days, he was transferred to the medical service. There, meningeal symptoms increased, choking of the discs occurred, and the patient died after 61 days in the hospital, about half of the stay divided on the surgical and medical services. His temperature was always hectic, and his leucocyte count was nearly 30,000 most of the time.

**Autopsy** showed that a perianal abscess had dissected anteriorly about the membranous urethra, extended through the levator ani on the left side of the perineum, and had advanced into the retroperitoneal spaces of both paravertebral gutters, with perforation of both diaphragms. Posteriorly on both sides the retropleural spaces were filled with pus. The lumbar and sacral plexuses transversed lakes of very foul pus. There was thrombosis of the left internal iliac vein, bilateral pyelitis and cystitis, a generalized purulent meningitis and bilateral otitis media. The abdominal and thoracic infections were of mixed type, while the meninges yielded only staphylococci.

## Discussion

A search of the leading surgical textbooks and the medical literature reveals a brief discussion of this condition under the title of pelvirectal abscess (Fig. 1) (1) A Cabot Case Report (2) probably described this condition, which was originally ascribed in the case report to a primary renal abscess. It is believed that ordinarily the pelvic diaphragm offers an effective barrier to the upward extension of infection about the anus. However, where the lesion of the bowel is above the pelvic diaphragm, or where a fulminating infection with gas-producing organisms extends upward via the lymphatics of the middle hemorrhoidal vessels, it is quite possible to have an extensive infection of the retroperitoneal spaces of the pelvis and abdomen. The writers on proctology thus advise early incision and drainage of ischiorectal abscesses without waiting for localization, in order to prevent this sort of complication. Such an extension may occur very rapidly as in the case herein reported that had been sick a relatively short time before the



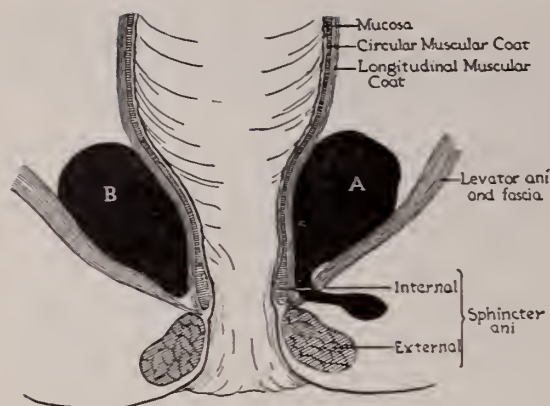


Figure 1

Deep pelvirectal abscess. A, perforating the levator ani muscle into the ischiorectal fossa (from Yeoman's "Proctology"). In the cases herein reported the infection at first may have been of this type, but rapidly extended out of the pelvic region as a spreading cellulitis.

ischioirectal abscess was opened widely, and yet a retroperitoneal extension subsequently occurred.

### Summary

Three cases are reported of extensive retroperitoneal infection which arose from the anus. Two cases died and one, in which early perineal and abdominal drainage was provided, recovered. This type of spreading retroperitoneal infection causes greater fever and lesser signs of spasm or tenderness of the abdomen than does peritonitis of an equivalent severity. The condition is probably more common than discussion in the text books and literature would indicate, and in general should be prevented by early incision and drainage of infections about the anus, and by early incision and drainage of the abdominal wall and retroperitoneal tissues when cellulitis has developed.

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Figure reproduced from Yeoman's Proctology by permission of D. Appleton-Century Co., New York.

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### NEW YORK SESSION OF A.M.A.

The week of June 10, 1940, has been selected by the Board of Trustees of the American Medical Association as the date for the Association's ninety-first annual session, *The Journal* of the Association for March 25 announces. The session will be held in New York. This year's session will be held in St. Louis, May 15-19.

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# How Towns Can Organize for Health\*

W. B. WALKER, M.D.  
Health Officer, Cornwall, Conn.

No doubt it seems strange that the person to address you on this subject is one whose public health training was only a short course in medical school some twenty years ago, and whose public health experience consists solely of being a small town health officer for twelve years. Probably the latter circumstance is the reason why I have been asked to discuss the subject; an attempt will be made in the light of this experience to point out some of the shortcomings of the present system, to suggest the remedy and its mode of application. Even though we have some knowledge of the ailment and what we consider might be a cure, it is true in this instance as in many others that it may be very difficult to persuade the patient to take the cure. "You can lead a horse to water, but you can't make him drink!"

## The Problem

It is surprising to discover in the accompanying map, prepared by the United States Public Health Service, that there are only ten states in the union which do not have any full-time local health service in the rural areas corresponding to the generally accepted standard applied to this term; and Connecticut is one of those states (Fig. 1). For the country as a whole, however, there is a total of 946 counties, townships, or districts, wholly or in large part rural, with a health service under the direction of local whole-time health officers. This represents 42 per cent of the total rural population.

This seeming backwardness of Connecticut may be more apparent than real, as the problem here is of course considerably different than that

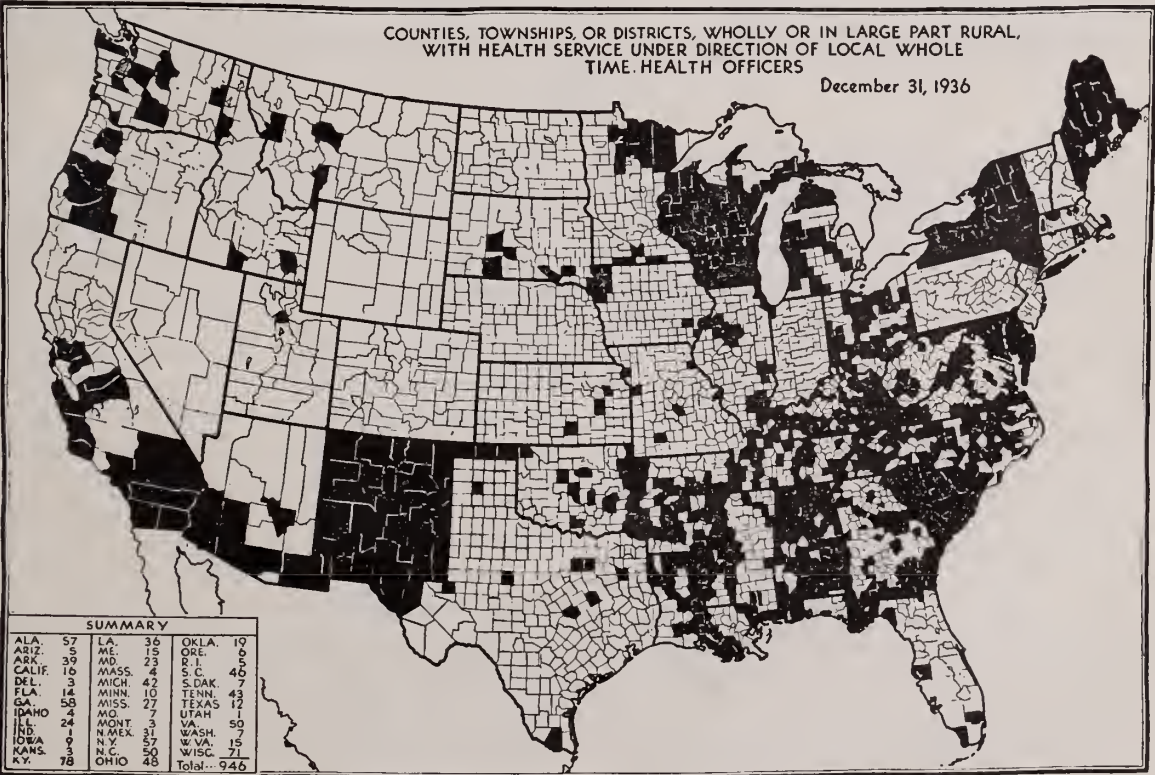


Fig. 1

\*Read at the meeting of Health Officers and the Connecticut Public Health Association, Middletown, Conn., November 30, 1938.

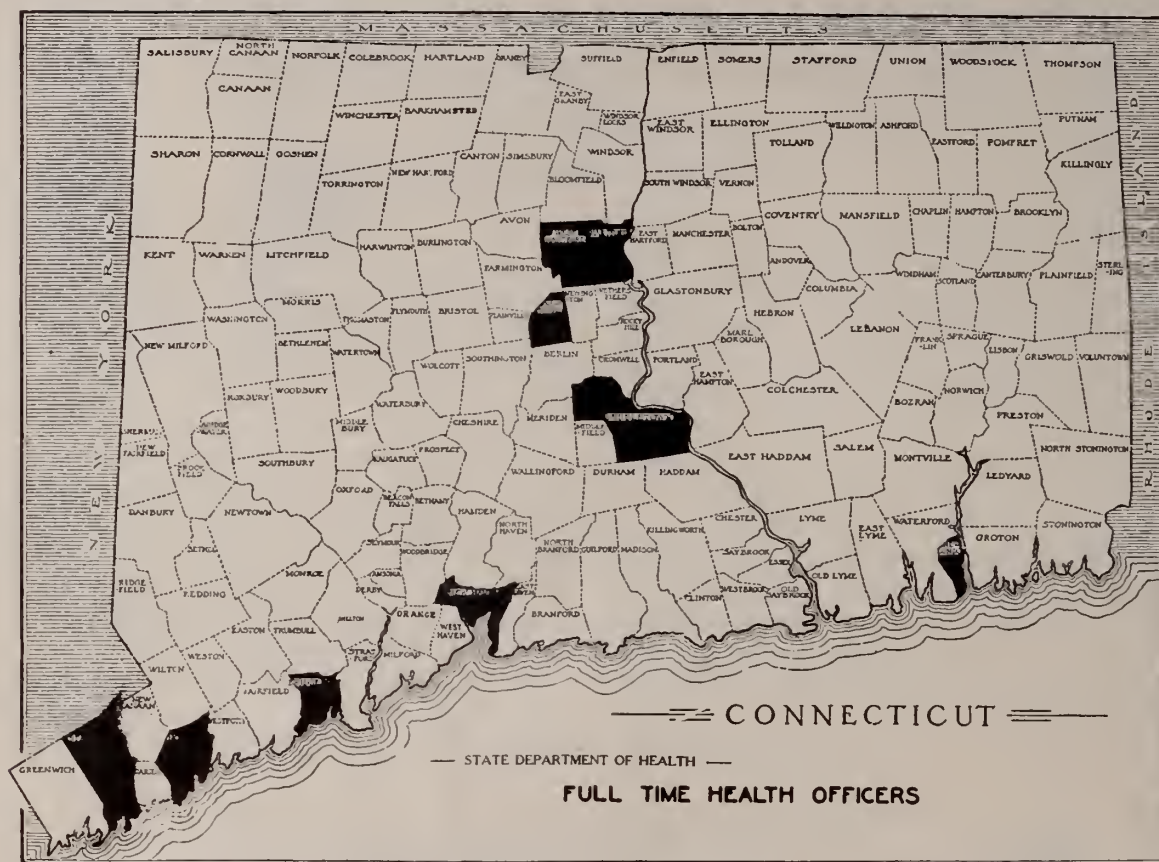


Fig. 2

in the larger states in the South and West with many counties and a more scattered population. The excellent service and supervision rendered by our State Department of Health makes the public health service rendered in Connecticut not quite as backward as the lack of full-time health units would indicate (Fig. 2). Although only a few of our cities have local full-time service, most of our towns have some full-time personnel such as public health nurses (Fig. 3).

We must admit that Connecticut has dropped a little behind in that we are using a system of health administration which dates back many decades. This system originated in the days when the chief duty of the health officer was to eliminate bad odors and public nuisances which were thought to be the cause of disease; and when many diseases, of which we now know the cause and methods of control, were thought to be "visitations of Providence" and were endured as such.

To examine more closely the present situation:

there are in the State of Connecticut 169 towns and with the divisions of townships and boroughs there are 178 health officers. Of this number many are laymen who can hardly be considered "Learned in medical and sanitary science" as required by statute. In many of these towns there is no physician to act as health officer, and physicians in neighboring towns are not willing to act in this capacity because of lack of interest in public health work or because of lack of time. The duties of health officer require a certain amount of correspondence and paper work which I can say from experience is difficult to fit in with the general practice of medicine. Naturally the busy practitioner cannot be expected to postpone his deliveries, his attendance upon a case of gall bladder or renal colic or coronary occlusion, to go see why Farmer Jones hasn't buried the cow that died in his pasture.

In order to gain a clear idea of just how much public health work is being done in small towns, I prepared Table 1 from the reports of the local



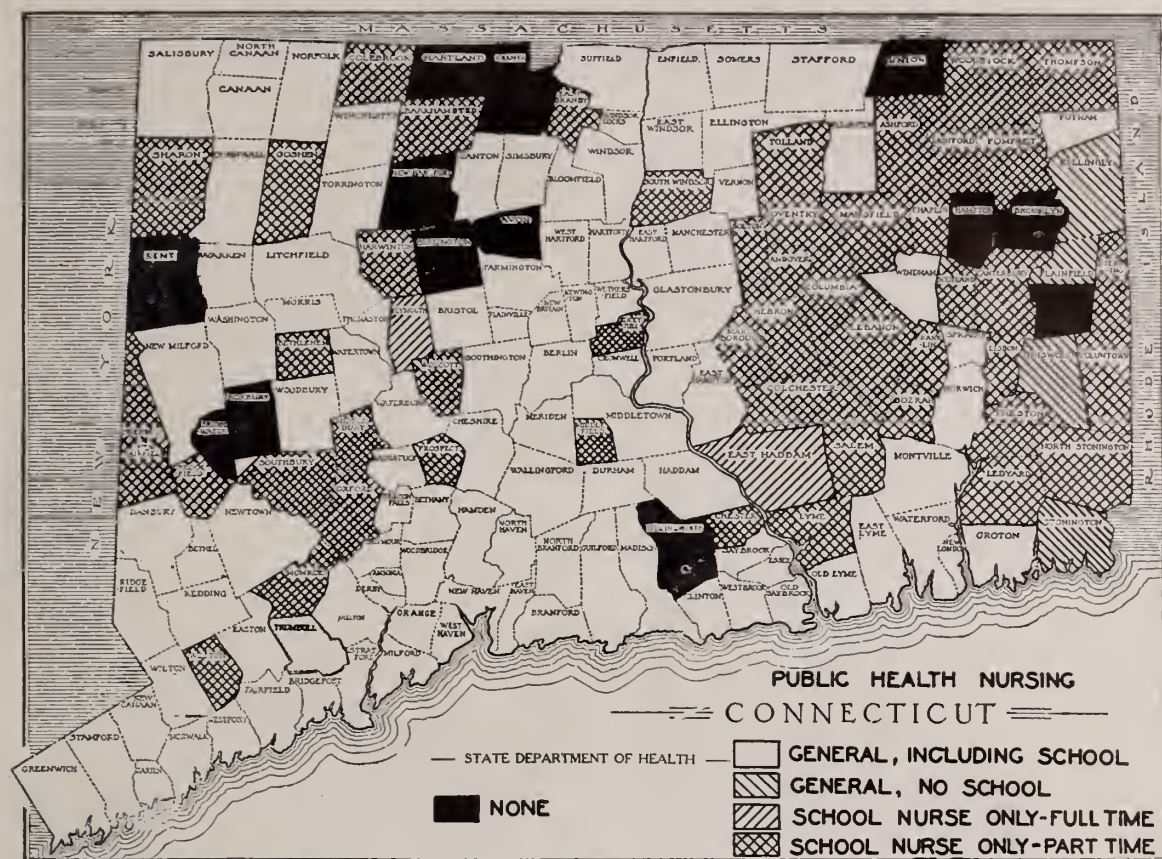


Fig. 3

health officers of Litchfield County for 1937. This would seem to give a rather sad picture of the public health work that is being done in this particular rural area and I do not believe this county can be taken as an outstandingly bad example.

There can be no argument that Public Health is a governmental function whether it is controlled by town, district, county or state, and we should no more think of conducting our war against disease with a large number of uncoordinated and inefficient armies than we would think of conducting any other war of invasion or defense in this manner. Public health service as it should be rendered today is simply impossible with the small local units by which it now functions and the small towns do not have the financial ability nor the available personnel to carry on a health program even approaching a decent standard.

**Table 1**  
**LOCAL HEALTH ACTIVITIES IN TOWNS IN LITCHFIELD COUNTY**

<i>Divisions</i>	<i>Number reporting any activity</i>	<i>Per cent</i>
Communicable Disease Control		
(Immunizations and Vaccinations)	9	35
Venereal Disease Control	7	27
Tuberculosis Control	0	0
Maternal Care	0	0
Infant and Preschool Hygiene	9	35
School Hygiene	11	42
Crippled Children	0	0
General Sanitation		
(Water Supplies, Sewage Disposal)	5	19
Inspection of Public Toilets	12	46
Food and Milk Supervision	11	42
Popular Health Instruction	6	23

Taken from annual reports of local health officers in the twenty-six towns of Litchfield County, for year ending August 31, 1937. No report received from four towns.

#### Possible Future Plans

What is the remedy? Three possibilities present themselves:



1. Combining of towns into Sanitary Districts.
2. Organization of the whole county as a Sanitary District.
3. Expansion of the State Department of Health.

With the present autonomy in the small towns, the latter proposition seems entirely out of the question. Organization by counties, particularly those having large cities, would make a large unwieldy unit which would include areas having considerable diversity of problems and interest. The best solution at this time would seem to be the combining of towns into Sanitary Districts which should have a population of something over 20,000 in order to function efficiently and economically. Such a combination is possible under our statutes. Towns, boroughs and cities are given the power to combine and form such a Sanitary District, the affairs of this district to be managed by a board on which each town, city or borough is represented by two persons. This board would set up a health organization with a minimum personnel of two to four which would include a full-time health officer, a sanitary inspector, and/or public health nurse and a secretary.

The powers at present given to the local health officer would go to the district health officer, and the local health officer's term of office would terminate with the creation of the district. The county health officer or officers, if towns in two counties should be included, also would automatically be a member or members of the Sanitary District Board so there would be no disturbance of the present county health officer set-up. Formation of such a Sanitary District in accordance with the statutes would present modern health protection to the smallest community at a cost that is within its reach. Funds are available through the State Department of Health which would supply one-half of the proposed budget up to a maximum of \$6000. Tables 2, 3 and 4 show examples of proposed budget; if the budget runs over \$12,000, the funds furnished through the State would not be more than \$6000.

The costs of maintenance of the district unit would be met by each town proportionally in accordance with the grand list, although it has been suggested that a more fair way to distribute

Table 2

**Health Officer and Clerk**

Salary, Health Officer.....	\$4000 to \$4500
Travel, Health Officer.....	300 to 600
Salary, Clerk.....	800 to 1200
Office Equipment.....	300 to 500
Office Supplies.....	200 to 400

TOTALS.....\$5600 to \$7200  
(One-half to come from state)

Table 3

**Health Officer, One Assistant and Clerk**

Salary, Health Officer.....	\$4200 to \$4500
Travel, Health Officer.....	300 to 600
Salary, Public Health Nurse or Sanitary Inspector.....	1650 to 1900
Travel of above.....	300 to 600
Salary, Clerk.....	900 to 1200
Office Equipment.....	350 to 500
Office Supplies.....	200 to 400

TOTALS.....\$7900 to \$9700  
(One-half to come from state)

Table 4

**District Department of Health**

Salary, Health Officer.....	\$ 4500 to \$ 5000
Travel, Health Officer.....	500 to 600
Salaries, Nurses (2).....	3500 to 3700
Travel, Nurses.....	800 to 1200
Salary, Sanitary Inspector.....	1650 to 1800
Travel, Sanitary Inspector.....	400 to 600
Salary, Clerk.....	900 to 1200
Office Equipment.....	400 to 800
Office Supplies.....	300 to 600

TOTALS.....\$12,950 to \$15,500  
(\$6000 to come from state)

the cost would be to proportion it in accordance with the average tax receipts as there is considerable variance between the rates of taxation. Levies would be made by the District Board on the town treasurer as funds are needed.

An example of the proposed expenditures may be found in the town in which I live. Its estimated population is 912 and the tax receipts average \$24,564. Under the proposed plan with an \$8500 budget, the cost to my town would be \$147. If the district were on the \$12,700 budget, there would be a cost of \$220 per year. What a small percentage this is of the tax receipts to expend for a public health service!

Let us estimate roughly the present average per capita public health expenditure and compare it with that under the proposed plan. The average per capita expenditure in 1937 for public

health activities in Connecticut was a little over 50 cents. The per capita expenditure to my town under the proposed plan with the smaller budget would be 16 cents and with the larger budget would be 24 cents. These figures do not include a full-time public health nursing service of the standard set up by the National Organization of Public Health Nurses, that is, a public health nurse for every 2000 of population. A few towns now have public health nurses and this service could be maintained as at present in co-operation with the Sanitary District. The ultimate ideal, of course, would be to have adequate full-time nursing service available to the whole population; but leaving this problem for later solution, we see that the average expenditure per capita would in some cases be no larger than at present, in many less, and it would unquestionably be such a small percentage of the average tax receipts that there could be no doubt about any town being able to afford it, if it would.

How may this district organization be brought about? With the present governmental system of local autonomy, the towns cannot be forced into combination of such a Sanitary District and it would be rather outside the pale of reason to consider that any such law could be passed. It will be necessary for interested persons, committees, or organizations to approach their towns by conference with their selectmen, by appearance in town meetings and before private and public organizations and clubs, to awaken public interest in the matter and make "John Q. Public" want it. When this is done and a sufficient number of towns have agreed by a vote of the town to enter such a district, placing in their budget sufficient funds to carry out the project, then such a Sanitary District may be formed. I am pleased to report that such a step is under way in Litchfield County. A short time ago officials and representatives of four towns were invited by the Bantam Lake Protective Association to a meeting where the subject was discussed and the representatives of these towns agreed to present in their town meetings the recommendation that these towns combine to form a Sanitary District. When and if these towns agree to such a proposition it is to be hoped that other towns will come in in a sufficient number to make the proposition feasible. Commitments are only for a period of one year and towns may withdraw at the end of the fiscal

year if it is found that the plan does not work out to their liking.

What may be the arguments against the proposition? The first, of course, would be that in some towns it would mean increased expenditures. We cannot expect a Connecticut town will be persuaded to do anything which might mean greater expenditure and higher taxes without careful consideration of the benefits. The increase for relief expenditures has been so great in the past few years that many towns feel they are too heavily taxed now and could stand no greater burden regardless of the advantages, but certainly a town should be willing to expend this small percentage of the average tax receipts for the improvement of community health without quibbling.

The second argument might be that the plan proposed increased centralization of power. This of course is impossible by the policy adhered to in the plan, as each town has a full representation on the board and each town is allowed to keep and make its own local health ordinances as before.

The third argument would be that some local health officers would be loathe to relinquish their positions which may bring a few hundred dollars a year. With greater public health activity I believe this difference to the local health officer who is a physician would be in large part made up by the greater number of immunizations, periodic health and school examinations, and so forth, which would be done under the promulgation of a full-time health program. I think too that it has been shown that the local units now are not functioning on the average in a manner to recommend their continuance in office. I grant that in some isolated instances there is no cause for criticism, although in general I believe that the good clinical physician does not necessarily make a good health officer.

Sir Arthur Newsholme made a statement some time ago that the practices of clinical and of preventive medicine were more or less twins and should go hand in hand. But Folks remarking on this subject believes that public health practice is different in many respects from the clinical practice of medicine. He prefers to see these two great services, for the present and for some time to come, one chiefly governmental and one chiefly individual, each established on its own feet, each adjusting itself to the other and to the



needs of the community from time to time. He does not want to see at this time any attempt to merge things that are as different as public health, a governmental service, and the clinical practice of medicine. This statement does not mean, of course, there should not be close co-operation between the two services but it does express the opinion shared by many that the practices of clinical and of preventive medicine have each become too complicated and are too different to function properly in the same individual. Public health administration has become too complicated and its growth has been too rapid for the general practitioner of medicine, without special training, to keep up properly with the developments in the field; certainly not if he makes any attempt whatsoever to keep up in the field of clinical medicine the progress of which has been no less rapid. The two branches of medicine, I believe, should be separate entities but should work together for the health and welfare of the people.

The fourth argument against an increase in public health service is that there is no necessity for increase, that the community is as healthy as possible. Any student of public health work who is at all familiar with the situation knows there is considerable room for improvement in many fields of public health administration, as we have previously shown, notably in the fields of communicable disease control, maternal hygiene, public health instruction, and crippled children's aid and there may be added work on such diseases as cancer, cardio-vascular diseases, etc. May I cite against this argument a couple of examples given by Dr. Arthur T. McCormack, State Health Commissioner of Kentucky, showing the advantages to be gained by more efficient public health work. In his own state of Kentucky, the death rate was reduced two-thirds in twenty-seven years and life expectancy increased from thirty-two to sixty years. He warns that this low rate cannot be continuously maintained because eventually those who have been saved from unnecessary illness and premature death during their earlier or productive years will succumb to the degenerative diseases of age, which are only now beginning to be studied with a view to their control. Another notable example is the Canal Zone where the death rate is today and has been for twenty years about one-half that of the registration area of the United States, and

the morbidity rate is approximately one-twentieth of that of this country. By these examples and many others it can be demonstrated to any thoughtful appropriating body that public health is purchasable and that good health can be secured for any community willing to pay the price.

The final argument which I will mention briefly is that under the proposed set-up politics may come to play too important a part in the selection and operation of the personnel. By politics of course we do not mean necessarily partisan politics; but there are personal, fraternal, racial and religious politics. A proper program of examination and training such as that set up by the New York Conference of Mayors and described by Capes offers a solution of this difficulty and insofar as the influence of politics goes in the present situation, let us remember that health officers of the Sanitary Districts must have certain qualifications which are set up by law and are prescribed by the Public Health Council. With this council appointed and functioning as it has in the past, there can be little question that the administration of public health activities in this state will be rendered without influence of politics.

### Summary

I have tried to show that the present local part-time health officer is not functioning efficiently as a local health unit and have suggested the solution against which I have raised and answered arguments. It will be necessary for a great amount of missionary work to be done in the towns before a sufficient number of towns can be brought to see that this further advancement among public health lines is needed, and this work must be done by persons who are interested in the advancement of public health and have "no bone to pick for themselves."

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## • Editorials •

### NEW HAVEN — MAY 25 AND 26

Connecticut is not so large that it will be impossible for any physician to drive from his home to New Haven on the morning of May 25 and reach there in time to hear the welcome extended by the president of the local county association. The Program Committee has arranged to start promptly at nine o'clock. The forenoon sessions will be devoted to papers on subjects which should interest all physicians and in particular the general practitioner. For many years the programs of the annual meetings were devoted to papers by our own members. Two years ago at Bridgeport we departed widely from that custom and offered to our members a program largely given over to guest speakers of national reputation. This year we return to local talent but happily are not confined to it, since there are to be several very distinguished guest speakers on the program. The function of our guests is rather a novel one in our Society meetings, that of summing up, adding to or discussing a group of papers presented by our members. Innovations never fail to add interest; we commend this new type of program to you.

The number of sections in our Society is steadily growing. These will occupy both afternoons and the second evening. If you do not find that you are a member of any particular group you are, notwithstanding this fact, welcome at the sessions of any section. Here, likewise, there will be opportunities to listen to many distinguished guests on subjects which they are eminently qualified to discuss.

The annual dinner always offers an opportunity to renew one's friendships and to enjoy the relaxation necessary midway in an intensive program. There are few writers of editorial comment more highly respected than the Editor of the Hartford Courant, Maurice S. Sherman, guest speaker at the annual dinner. "Political Therapeutics" should have much of interest for all.

As adjuncts to the scientific program there will be an industrial medicine display and a commercial exhibit. A large number of the

commercial exhibitors are advertisers in the Journal. To them we are indebted for financial support and friendly interest. This will be our opportunity to reciprocate by visiting their exhibits and interesting ourselves in the latest products offered.

New Haven is accessible, the program is an excellent one, Hotel Taft affords us ample accommodations. Make your plans now to be on hand May 25 and 26, not one day but both.

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### THE LAST WORD ON INSURANCE

Believing that the Journal can be of service to the physicians of Connecticut in the proper selection of accident and health and of life insurance it is offering in this issue the first of a series of articles by experts in these types of insurance. The information is offered impartially with no idea of including any form of sales talk. If such should creep in unawares it will be without intent or forethought and we hope will be overlooked. Not only do we believe that the physician of our State will welcome sound advice in the selection of insurance but also in the utilization and disposition of that which he may now possess. Should any problems present themselves to the individual as a result of these articles it is suggested that his local underwriter be consulted for further advice. We shall be indebted to several insurance experts for their willing assistance in making these articles available to our readers.

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### MAY 1 — CHILD HEALTH DAY

"The Health of the Child Is the Power of the Nation." This, the Child Health Day slogan for 1939, is particularly appropriate since this year is to be a year of national stock taking in the field of child health and welfare. The origin of the Children's Bureau, and even of the Department of Labor, of the federal government was indirectly due to the national feeling of rebellion aroused by child labor injustices during the last century. In 1916 the President endorsed the first Nationwide Baby Week and May Day was suggested as a day in which to celebrate the increase in knowledge which has resulted in the improving health of our children. Child health needs were assessed at this time. In 1928 the President was authorized by Congress to issue

an annual May Day proclamation. In 1935 the Association of State and Provincial Health Officers of North America asked the Children's Bureau to sponsor May Day Child Health Day.

Thus we approach May Day 1939, the fourth year of the sponsorship of Child Health Day by the Children's Bureau. This day long has been one of festival, characterized by May-pole dances, distributing of flowers by happy children, a day given over to the young and to the beautiful in life. What more pleasant tradition exists among the English speaking peoples than May Day? We pause this year to thank God for the increasing health of our children, the product of years of scientific research. We look forward to years of increasing child health through better prenatal care, lower maternal mortality, better housing, better food, more efficient immunization against disease. If our stock taking is to produce results we anticipate a better understanding of our own problems of child health and eventually the gradual attainment of a solution to these problems.

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### 2,000,000 MOTHERS

At any given time there are approximately 2,000,000 pregnant women in this country, and some significant data concerning them have recently been analyzed by the Metropolitan Life Insurance Company. One-third of these expectant mothers are between twenty and twenty-four years of age, and in this group the maternal mortality is the lowest. Very young mothers present a considerable higher mortality rate. As age advances the maternal risk increases,—between the ages of thirty-five and thirty-nine the mortality rate is twice that of the years twenty to twenty-four, and between forty and forty-four years the rate is three times as high.

It is a well known fact that a high risk attends the birth of the first child, and these statistics show that the mortality of mothers is lowest for the second and third child, and increases somewhat irregularly with succeeding births. There is a rather unexpected connection between the mortality of the mother and the viability of the child born. Premature birth, still-birth, or miscarriage frequently result from a condition which also jeopardizes the mother's life. Maternal mortality associated with still births is sixteen times that accompanying live births. Statistics



in connection with abortions are inexact, but it has been estimated that there are from 8,000 to 10,000 deaths annually arising from abortions. The unfavorable circumstances that surround illegitimacy also influence maternal mortality, and from the figures available it is concluded that the mortality rate is twice that encountered in legitimate births.

During the past few years there has been a considerable lowering of the maternal mortality rate in the United States, which has been brought about, in part at least, by an improvement in prenatal and subsequent care, but it is pointed out by the Metropolitan analyst, prenatal care alone is not sufficient, and of greater importance will be improvements which must be brought about in obstetrical practice, for even with the best prenatal care, if obstetrical practice is deficient, maternal mortality cannot be reduced to the minimum.

C.B.



#### SPECIAL LECTURE BEFORE ANNUAL MEETING

The Department of Anatomy of the Yale University School of Medicine invites the members of the Connecticut State Medical Society to attend the Woodward lecture to be given in the auditorium of the Sterling Hall of Medicine at 8:30 P.M., Wednesday, May 24, the evening before the opening of the Annual Meeting of the Society. Dr. E. V. Cowdry, Professor of Anatomy, Washington University School of Medicine, St. Louis, will present an address on "Problems of Ageing". Dr. Cowdry is an editor of a book on this subject and has demonstrated a comprehensive viewpoint of the problems of old age which have become of increasing interest to physicians.



#### POST-GRADUATE OBSTETRICAL COURSE A SUCCESS

The recently completed post-graduate course

for physicians in obstetrics, conducted by Arthur H. Morse, M.D., and Herbert Thoms, M.D., at the Yale University School of Medicine, proved very interesting and instructive for all those who attended.

The course consisted of a series of six meetings held on Friday afternoons from 3 to 5 P.M. During this course a number of obstetrical subjects were discussed in a concise and comprehensive manner, and the lecturers were very considerate to include any topics the members of the class requested. Following the lecture, ample time was allowed for general discussion and presentation of problems or interesting cases.

Many physicians in Connecticut will welcome the fact that Dr. Morse plans to repeat this course at a later date.



#### OBSTETRICAL CONSULTING SERVICE EXTENDED

Hugh B. Campbell, M.D., President of the State Medical Society, announced at the spring meetings of the county medical associations that physicians may now obtain an obstetrical consultant under the "Connecticut Obstetrical Consulting Service" for those maternity patients who are residents of a town with a population of 50,000 or less. Previously this service has been accessible to towns with a population under 30,000.

The Connecticut Obstetrical Consulting Service is available at any time during the antepartum period, as well as at the time of delivery, or during the postpartum period. *It is intended for patients who are unable to pay for a consultation themselves and for whom no other provision can be made.* At the present time the only towns for which this service is not available are Bridgeport, Hartford, New Britain, New Haven, and Waterbury.

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# From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street

New Haven

## DELEGATES

The House of Delegates will have its annual meeting on Wednesday, May 24, the day preceding the opening of the Annual Meeting of the Society. The House of Delegates will meet in the auditorium of the New Haven Medical Association at 364 Whitney Avenue, commencing at 10:30 o'clock in the morning. An adjournment will be made for luncheon which will be served to members of the House. The meeting will continue through the afternoon. There will be no meeting of the House on the first day of the Annual Meeting, May 25; the final meeting of the House will be held in the morning of May 26 at the Hotel Taft. The agenda for the meeting of the House will be distributed to all members about May 15. Delegates who are unable to attend either of these meetings should notify the secretary of their county association as promptly as possible in order that an alternate may be designated. According to the By-laws of the Society the delegates are apportioned as follows: Fairfield, 11; Hartford, 15; Litchfield, 3; Middlesex, 2; New Haven, 15; New London, 4; Tolland, 1; Windham, 2.



## LEGISLATIVE ACTIVITIES

The Secretary wishes to take this means to thank the members of the Council, the members of the Society's Committee on Public Policy and Legislation and the Presidents and Secretaries of the County Associations for their prompt and generous cooperation in connection with matters pending before the General Assembly. Be assured that your efforts were fruitful. The Society is especially indebted to Dr. William H. Coon, representative from the town of Easton, the only physician member of the General Assembly, for his understanding helpfulness. Our legislative purposes and projects have thus far progressed favorably.

## ADVISORY COMMITTEE TO STATE NURSES' EXAMINING BOARD

The Council has approved the request from the State Nurses Examining Board for the appointment of two members of this Society to serve on an Advisory Committee to that Board. Dr. B. Austin Cheney and Dr. Claude C. Kelly will be the Society's representatives.



## COMMITTEE ON PERSONNEL STUDY

The Committee appointed by the Council at the request of the Personnel Director of the State of Connecticut to study the conditions of physicians' employment in State Institutions has completed its work. The Committee, consisting of Drs. Stanhope Bayne-Jones, David R. Lyman and Wilmar M. Allen, has submitted its report to the Personnel Director of the State and it is contemplated that the Committee will be continued to act as advisors to the Department.



## SPEAKERS SERVICE

Dr. James Raglan Miller and Dr. Oliver L. Stringfield have recently addressed civic organizations in Southington and Fairfield on the subject of government medicine. These addresses were part of the program that was arranged by this office whereby physician speakers would be provided for such meetings. During the winter we have arranged programs for ten meetings of public forums, service clubs, church and civic groups.



## OUR DELEGATES TO OTHER SOCIETIES

To the American Medical Association — St. Louis, May 15-19, 1939.

George Blumer, New Haven.

Walter R. Steiner, Hartford.

To the Maine Medical Association — Poland Springs, June 25-27, 1939.

Clyde L. Deming, New Haven.

Alfred C. Henderson, Stamford.

To the Massachusetts Medical Society —  
Worcester, June 6-8, 1939.

Philip G. McLellan, Hartford.  
Stanley B. Weld, Hartford.

To the New Hampshire Medical Society —  
Manchester, May 16-17, 1939.

Thacher W. Worthen, Hartford.  
Paul R. Felt, Middletown.

To Rhode Island Medical Society — Providence, June 7-8, 1939.

Daniel Sullivan, New London.  
Cecil R. Garcin, Danielson.

To Vermont State Medical Society — Burlington, October 6-7, 1939.

Appointment to be made by the House of Delegates.

To the Medical Society of New Jersey — Atlantic City, June 6-8, 1939.

James R. Miller, Hartford.  
Oliver L. Stringfield, Stamford.

To Medical Society of The State of New York — New York, April 24-27, 1939.

Charles H. Turkington, Litchfield.  
D. Chester Brown, Danbury.

To Connecticut State Dental Association — Bridgeport, May 3-5, 1939.

James D. Gold, Bridgeport.

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#### RADIUM IN CORPUS CANCER

At the Radiumhemmet (Stockholm Sweden) a new method of treating corpus cancer with radium has been lately introduced. I call this method "packing of the uterus." The uterine cavity is packed with a number of radium tubes (10 to 20) so that the radium comes in close contact with the entire area involved. The uterus generally contracts around the pack and the risk of any small focus being left unexposed thus considerably reduced. — *Heyman, Calcutta Med. Jour., Jan. 1399.*

## SECTION ON Orthopedic Surgery

**Care of the Crippled Child.** One must not forget that a number of crippling conditions in children materially affect their speech. This particular phase of rehabilitation is cared for under the Division of Crippled Children in the State of Connecticut through therapeutic speech training. This is a very valuable addition to the program and is especially useful in cases of cleft palate and cerebral palsies. How often in the past one would see a physically rehabilitated young adult who could not, however, develop the necessary contacts for real socialization because of his speech defect.

**World Congress for Workers with the Crippled Children.** During July of this year an international congress will meet in London, England, for the purpose of exchanging ideas and furthering the work with the crippled child. Our National Society for crippled children expects to have a large delegation in attendance. This opportunity for cross pollination of ideas should be taken by all those who are concerned with the handicapped child.

**Spontaneous Poliomyelitis in Hogs.** Once more a Swiss investigator reports symptoms observed in hogs that greatly resemble those of acute anterior poliomyelitis. After the animals died, sections were studied of the spinal cords. These showed a rather typical myelitis rather than those characteristic of poliomyelitis. However, the investigators felt sure that the disease process was actually anterior poliomyelitis. They believe that more careful observations upon animals will show that the disease may be transmitted from animal to animal and possibly from animal to man or from man to animal. This observation was reported in the Swiss Medical Journal of January 28, 1939.

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(SEE PAGE 2.)



**Orthopedic Shoes.** From Germany comes an interesting bit of legislation. Now orthopedic shoes can be made only by cobblers who are qualified and who have received a specific certificate stating their qualifications. The word "orthopedic" when applied to a shoe has been grossly misused and conveys a false idea both in Germany and here in the United States. This new law in Germany certainly represents an improvement, assuring orthopedic foot care will in the future be orthopedic in fact as well as in name.

**The American Journal of Surgery.** For the past few months, the American Journal of Surgery has devoted single issues to classified subjects and presented each as a symposium for the subscriber's edification. The April issue of this year is a symposium on the surgery of the extremities, edited by W. W. Babcock. It is quite comprehensive with the articles written by many of the leading general surgeons and orthopedic surgeons of the country. It can be purchased separately and belongs in every orthopedist's reference library.

#### **Orthopedic Society Meeting — Germany.**

The International Society of Orthopedics and Traumatology will meet in Berlin, September 4-8 of this year. The program includes many outstanding orthopedists of Europe and America. It is interesting that this meeting should be held this year within Germany. There is more than likely a story behind the selection of Berlin for the 1939 meeting.



#### **NOTICE TO JOURNAL A.M.A. SUBSCRIBERS**

If you are in an office with one or more physicians and each of you is a Fellow of the American Medical Association, it is likely that all of you receive copies of the A.M.A. Journal. We are informed by the American Medical Association that in cases of that kind other scientific publications of the A.M.A. may be substituted for the Journal. By this arrangement, one man in the group could elect to take the Journal, the others could take some other publications, thus affording that office access to two or more of the several A.M.A. publications without extra cost.

## **SECTION ON Proctology**

### **MEETING OF SECTION**

As announced on another page of the Journal, the projected section on Proctology will hold its organization meeting at the Hotel Taft May 25, 1939, at 4 P.M.

The following men have written to signify their interest in the formation of this section:

Dr. J. Grady Booe, Bridgeport.  
Dr. Charles L. Corradino, New Haven.  
Dr. Albert R. Keith, Hartford.  
Dr. Simon B. Kleiner, New Haven.  
Dr. Morris Levinsky, Bridgeport.  
Dr. Edward F. Malloy, Stamford.  
Dr. Edward Ottenheimer, Willimantic.  
Dr. J. C. Quatrano, Bridgeport.  
Dr. Andrew Taylor, East Hartford.  
Dr. Frank D. Ursone, Norfolk.

It is expected, in view of the interesting paper to be presented, that many internists and general surgeons will also attend the section meeting. Anyone interested in the subject of Anorectal Tuberculosis is welcome.

### **NEW ENGLAND PROCTOLOGIC MEETING**

The spring meeting of the New England Proctologic Society was held on Friday evening, April 21, in Worcester, Massachusetts. The program was arranged by Dr. P. A. Brooke of Worcester.

### **MEETING OF NEW YORK PROCTOLOGIC SOCIETY**

On the evening of April 20 the New York Proctologic Society met at the Auditorium of the Wickersham Hospital in New York City. A very interesting program was presented. Dr. R. Turell reported a case of "Immuno-Transfusion in Chronic Bacillary Dysentery", while Dr. I. Kalow reviewed the literature on "Treatment of Ulcerative Colitis". The paper of the evening was presented by Dr. Martin G. Vorhaus. His subject was "Vitamins in Gastro-Intestinal Diseases with Special Reference to Colonic Disorders". The discussion was opened by Dr. Mills Sturtevant.

## Our Neighbors

### NEW YORK

The Medical Society of the State of New York reports \$157,674.00 in dues collected for the year 1938. The cost of administering the Society for that year was \$139,450.71. There were extra budgetary expenses amounting to \$5,729.31. With the beginning of 1939 the Journal of the Medical Society of the State of New York was taken over and operated by the Society itself. It now appears changed in format and possibly somewhat easier to read.

### RHODE ISLAND

In January, 1939, the Managing Editor of the Rhode Island Medical Journal reported to the Council that he had submitted his resignation as Editor of the Journal to the Committee on Publications over a year ago. Apparently no one can be found to succeed Dr. Albert H. Miller. A peculiar situation exists in the Rhode Island Medical Society. It gives no support to its Journal; it has no provision for secretarial work; although the Committee on Publication is elected by the House of Delegates, the Council has transferred the financial control of the Journal to the Treasurer of the Society, an arrangement which seems to handicap the Editor. The Managing Editor warns the Society that he shall suspend publication at his own convenience and without further notification.

The Rhode Island Medical Society, through its legislative committee, has introduced recently into the General Assembly of that state a revised Basic Science Act which it hopes will become a law during the present session. The Act calls for a board of examiners in the basic sciences, to be composed of three members serving staggered terms of one, two and three years. One member is to be chosen from the faculty of each of the three institutions, Brown University, Providence College and Rhode Island State College, each one selected for his knowledge of the basic sciences. Each member of the board cannot be actively engaged in the practice of the healing art or any branch thereof and is to be appointed by the Director of Public Health. The new board will supplement the existing professional boards as in other states where such a Basic Science act is in operation.

## - NEWS -

### *from County Associations*

### Fairfield

The Stamford Medical Society was host to the Fairfield County Medical Association on the evening of March 14 at Stamford Hall. Dr. Isadore S. Ravdin, Professor of Surgery of the University of Pennsylvania Medical School, gave a paper on "The Diseases of the Gall-bladder and Bile Ducts." Beginning with the physiology of the biliary tract, he discussed the advantages of a high carbohydrate-protein diet as a pre-operative measure to combat liver injury; he considered the most advantageous types of anesthesia and spoke of the role of vitamin K and oral ingestion of bile salts in the prevention of hemorrhagic diathesis. The discussion of the paper was opened by Drs. McCreery and Hertzberg.

On Wednesday, March 1, a testimonial dinner was given at the University Club in Bridgeport, in honor of Dr. James Douglas Gold, long time member and present Chairman of the Council of the State Medical Society, and Dr. D. C. Patterson, a recent president of the State Society and member of the State Board of Medical Examiners. The Committee on Arrangements, Drs. Sprague, Howard, Parmelee and Weise, are to be highly congratulated on their planning of the program. Dr. Griffin filled the post of toast master in his usual inimitable manner. Dr. Hugh Campbell, as President of the State Society, brought greetings from the state organization. Dr. D. Chester Brown and Dr. William M. Stahl were present from Danbury. Dr. Patterson read excerpts from answers by candidates before the State Board of Medical Examiners, one of which reminded the hearers that an early sign of prostatic hypertrophy is a diminution of the parabola. Dr. Gold told somewhat of the history of the Council and of his trips about the state to the meetings of the County Societies, often in the company of Dr. Creighton Barker. (Memories of Mr. Pickwick.) The Reverend Hugh Shields topped off a delightful evening with bits from his great store of anecdotes and one or two request selections from James Whitcomb Riley.



## Hartford

At the 147th annual meeting of the Hartford County Medical Association held in Hartford on April 4 the following officers were elected: Henry N. Costello, president; William T. Morrissey, vice-president; Frank T. Oberg, secretary-treasurer; Edward J. Whalen, councilor; Benedict N. Whipple, censor; D. C. Y. Moore, member committee on public policy and legislation; James R. Miller, Edmund R. Zaglio, Timothy F. Brewer and B. Bayliss Earle, delegates to the State Medical Society. Seventeen new members were elected. The delegates to the State Society were instructed to favor a full time secretary.

## Litchfield

The Litchfield County Medical Association held its annual meeting on April 25 at the Litchfield County Hospital. Dr. John A. Wentworth of Hartford delivered an address on the subject "The Doctor Looks at Himself". Preceding the meeting the members of the society were the guests of the hospital at luncheon. The meeting was in charge of the President, Dr. Floyd A. Weed of Torrington.

During the current month, the date not yet fixed, Bert G. Anderson, D.D.S., will speak to the Torrington Dental Society at the Charlotte Hungerford Hospital. Dr. Anderson will discuss recent developments in the Development of Dental Surgery in the Medical School of Yale University. Graduates in Dentistry are now being received in the medical school as candidates for the M.D. degree.

Plan for Hospital Care, Incorporated, working under contract with hospitals in Litchfield County at New Milford, Torrington and Winsted, as well as in sixteen other hospitals in the state, has opened an office at 106 Main Street, Torrington (telephone 8606), for the co-ordination of its work in Litchfield County.

Monthly meetings of the Auxillary of the Charlotte Hungerford Hospital have been held since September under the direction of Mrs. W. A. Gleason, President. On April 12 a benefit bridge attended by more than 300 members of the organization and friends resulted in an increase in the funds of the treasury by two hundred dollars. The annual dinner meeting is to be held during May. Numerous valuable gifts and contributions to the welfare of patients have

been provided by funds furnished by this loyal and interested group of women.

The Tumor Clinic of the Charlotte Hungerford Hospital which has completed the second year of its activity is now holding its meetings at the hospital at eleven a.m., on the second Wednesday of each month. Physicians interested in the work of the clinic are cordially invited to attend.

Dr. and Mrs. E. H. Wray of Litchfield have recently returned from a motor trip to Florida.

Through the generosity of the Executive Committee of the Board of Governors, the Charlotte Hungerford Hospital recently acquired a 16 mm. projection apparatus which will be used for the showing of films of medical educational value and scientific interest to the staff.

At a recent meeting of the Torrington Dental Society Dr. Gustav Wilens gave an interesting and instructive address on pathological conditions of the oral cavity. Dr. Wilens illustrated his talk with lantern slides and histological section.

The following program has been prepared by the Journal Club of the Charlotte Hungerford Hospital for the period ending June 1939. Physicians interested in any of the subjects described are invited to attend the meetings which are held in the Staff Conference Room of the hospital.

Date	Program
5-4-39	—Speaker: C. Y. Bidgood, M.D., of Hartford, Connecticut, by invitation.
5-11-39	—Films: Surgical Treatment of Peptic Ulcers.
5-18-39	—Speaker: H. J. Root, M.D., of Waterbury, Connecticut, by invitation.
5-25-39	—Films: Cholecystectomy and Choledochostomy. Depressed Fracture of Skull. Full Thickness Skin Graft. Dorrance's Push-Back operation for Short Palate.
6-1-39	—Speaker: E. Myles Standish, M.D., of Hartford, Connecticut, by invitation.
6-8-39	—Films: Thyroidectomy in Detail. Subtotal Thyroidectomy.
6-15-39	—Films: Subtotal Gastrectomy. Modified Mikulicz Operation.
6-22-39	—Speaker: R. T. Ogden, M.D., of Hartford, Connecticut, by invitation.

### Middlesex

Dr. Carl P. Wagner, Physician-in-Charge of Elmcrest Manor, reports that the capacity of the sanitarium has been increased during the past year and that additional treatment facilities have been added in order to render a better service.

Marlborough House was opened in October with additional patients' rooms on the second floor. The first floor of this building is devoted to recreation rooms, Hobby Shop and Art Studio. Within the next few weeks part of this building will be remodeled to supply additional rooms for physical therapy, and a separate building will be opened with Hobby Shop and Art Studio, where instruction will be given in metal work, jewelry making, leather work, knitting and costume designing. A well qualified instructor has been employed to teach these crafts.

The summer program for physical education includes golf, tennis, lawn bowling, soft ball, badminton, deck tennis, ocean bathing and horseback riding.

The nursing staff has been increased in order to bring about closer supervision of the patients' activities.

Since the hurricane last fall the hospital park has been re-landscaped and many new plantings made. Informal plantings of evergreens and white paper birches have been made along Marlborough Street to screen off the hospital park and give additional privacy to the patients.

In keeping with the policy of the sanitarium to render a service that will meet the needs of the physicians in the community, a special service has been established for the treatment of the so-called "alcoholic". Two types of service are available. One for the patient who can spend a long period of time under psychiatric care and supervision. An effort is made to give these patients psychiatric insight and to teach them to handle life's problems without resorting to the use of alcohol as an escape. A second type of service is designed purely to meet the practical needs of some patients. An attempt is made to get these patients over the acute toxic condition by elimination, proper diet and vitamin therapy, to build them up physically and to give them such psychotherapeutic assistance as it is possible to give in a limited period of time.

### New Haven

Dr. Morris Fishbein, Editor of the Journal of the American Medical Association, appeared before the Yale Political Union on the evening of April 14 in a debate on the subject of "Socialized Medicine". It is unnecessary to state which side of the argument Dr. Fishbein supported. Never has the writer heard him in better form. Facts, figures, data explaining the position of organized medicine and discrediting the arguments of the opposition rolled forth from his lips in a lucid stream and in such a manner that they never served to confuse the issue or cloud the argument. In particular, Dr. Fishbein indicted the social workers for trying to practice medicine or attempting to tell the physician how instead of confining their efforts to the tasks of liaison work and assisting in the social side of medical practice.

### New London

S. P. Tombari, M.D., a general practitioner in Norwich since 1936, was married in West Haven on February 21, 1939, to Miss Cecelia Spissak. Dr. Tombari is a graduate of Connecticut State College and of Boston University School of Medicine. From 1934 to 1935 he was an intern at St. Raphael's Hospital and the following year served the same hospital as resident. After a short trip to the West Indies Dr. and Mrs. Tombari took up their residence in their new home on the Salem Turnpike, East Great Plains, Norwich.

Dr. K. K. Markoff met with a serious accident to his eye on February 9. This accident confined him to the hospital for some time, and he has since been treated in New York. We are pleased to see him back at work again, and he reports that he is likely to retain the use of this eye.

Dr. Henry A. Archambault had his appendix removed on March 3 and returned to his office on April 1.

A son, Michael John F. Moore, was born to Dr. and Mrs. M. R. Moore on March 12.

Dr. Alfred Labensky of New London returned April 10 after a month's absence during which time he attended a post-graduate course in internal medicine at Baltimore. This course was given under the auspices of the American College of Physicians. During his absence he also visited relatives in Michigan.



Dr. Edward Gipstein has recently returned after a years' absence. He spent some time in England and on the European continent at post-graduate work in cardiology.

Dr. Frank Dunn has moved his office to his home and we all join with him in being very happy that he has recovered sufficiently to be practicing medicine once more.

Dr. Shirley Baron has left to attend a course in the medical department of the University of Indiana.

## Letters to the Editor

Litchfield, Conn.

To the Editor of the Journal:—

Dr. Childs handed the enclosed to me and I think it worth copying in the Journal. Maybe you have room for it is pretty good.

Sincerely yours,

Charles H. Turkington, M.D.

### WORK, THE BEST REMEDY

To the New York Herald Tribune:

Your editorial article "A Premature Program," which concerns Senator Wagner's "modest approach" to a national health program by way of a bill carrying an appropriation of \$80,000,000 is apt and timely. As you say, common sense suggests a postponement until a durable recovery is in progress, and the national income can stand it. But this is not quite a complete statement of the case.

When a durable recovery is actually in progress, there won't be any need for Senator Wagner's program and there won't be any need to worry about the national income's ability to stand the strain. The need for extension of the present social security program and its proposed consort, the national health program will be gone with the wind just as soon as, and no sooner, than Americans can get back to work for wages.

During the last year I have had opportunity to make special studies of health and welfare administration in Maine, Connecticut, and New York State. In all of these studies, ample evidence was found to justify the conclusion that no other thing except capacity increase of opportunity for the people to work for wages is needed to put all America back on its feet. That is the only thing which will permit a return of Americans to self-support and self-respect. The universal reply of Americans everywhere to the question, "What do you need most?" is "A good job at fair wages."

The sole objective of the social security program is self-support for the individual and his family. If this

objective is not made the *sine qua non* of government effort, there is nothing worth while in any national or state program of social readjustment or health betterment. Self-support for Americans means, first of all, good jobs at fair wages—nothing more, nothing less. Those incapable of that kind of support can be dealt with intelligently only when we have eliminated from the relief rolls those who want jobs and wages more than anything else, and that means most worth while Americans. And when we have eliminated them, there will be few states incapable of solving their own health and welfare problems intelligently and economically.

The much talked about one-third of the nation, which is ill-fed, ill-housed, and ill-clothed, is nothing but a political statistic which has no significance whatever unless it is tested by an application of a known and reasonable standard of measurement. The standard of measurement used by our authorities in Washington is not known, and if it were, it would likely be any more reasonable than the social security plan itself.

The statistic will not even have value for political purposes when jobs at fair wages are ready for those who want work.

As a physician student of human behavior in health and disease this one thing I am sure of, after a life-time of experience. Given mental and physical fitness for self-support and an opportunity to enjoy self-support and the freedom of regular work for regular pay no man can any more refrain from working than he can refrain from breathing. Constructive, useful work is as necessary to a man's life and happiness as his breath. And if he gets the work and wages you can bank on it that he will get the rest of what he needs without anybody's help.

I suppose such a plan of social security for Americans is too simple to receive the approval of any one but simple-minded doctors like me. My trouble is, perhaps, that being a country doctor's son, I was early taught that it is mighty good practice to try the simple remedies first. They are cheaper and, besides, nature is likely to respond more readily for the patient's cure if she isn't overwhelmed with complicated and drastic prescriptions. It's a good idea for a doctor to hold something in reserve until he finds out whether the patient is going to need it or not. This is a tip to Senator Wagner and the President's advisors on social security and the nation's health.

Not only can the national health and welfare problems be solved readily by the states without guidance from Washington, if the national economic policies are adapted to the purpose of creating regular jobs for regular wages, but every other problem of living and human relations now agitating the bosoms of our zealous reformers in Washington, will likewise be simplified. The problems of social security, taxation, labor-capital relations, defense against "isms" and European ideologies will, under a program of industrial recovery, reduce themselves to simple, common-sense American proportions.

Carl E. M'Combs, M.D.

New York, March 7, 1939.

## SPECIAL NOTICES

### COMINGS MEETINGS

American Medical Association—St. Louis—May 15-19  
 Maine Medical Association—Poland Springs—June 25-27  
 Massachusetts Medical Society—Worcester—June 6-8  
 New Hampshire Medical Society—Manchester—June 8-9  
 New Jersey, Medical Society of—Atlantic City—June 6-8  
 Rhode Island Medical Society—Providence—June 7-8  
 Vermont State Medical Society—Burlington—October 6-7

### ANNUAL MEETING—NATIONAL TUBERCULOSIS ASSOCIATION

The National Tuberculosis Association will hold its 35th annual meeting in Boston, June 26-29. The detailed program of the medical sessions will appear in the June issue of the Journal. All physicians are cordially invited to attend any or all of these sessions. There is no registration fee. The National Tuberculosis Association has not met in New England in twenty one years. Dr. Reginald Fitz of Boston is chairman of the Committee on Arrangements.



### SPECIALISTS PLAN MEET IN CHICAGO IN OCTOBER

The fourty-fourth annual convention of the American Academy of Ophthalmology and Otolaryngology will be held in Chicago October 8-13 at the Palmer House, a bulletin announces.

The academy has a membership of about 2,800 eye, ear, nose and throat specialists and the attendance at meetings is usually well over 2,000. It is said to be the largest organization of specialists in the United States.

About half the program is devoted to formal addresses, but fully half the week's activities consist of "instructional courses," in which the doctors go to school in earnest, with hundreds of eminent specialists as their instructors.

Dr. George M. Coates, Philadelphia, is president this year and Dr. Albert C. Snell, Rochester, N. Y., is president-elect.



The 63rd annual convention of the American Association on Mental Defect will be held at the Palmer House in Chicago, Illinois, from May 3rd to 6th, inclusive



### 1939 GRADUATE FORTNIGHT of

#### THE NEW YORK ACADEMY OF MEDICINE

The Twelfth Graduate Fortnight of The New York Academy of Medicine will be held from October 23 to November 3, 1939.

The subject of this year's Fortnight is THE ENDOCRINE GLANDS AND THEIR DISORDERS. The purpose of the Fortnight is to make a complete study and authoritative presentation of a subject of outstanding importance in the practice of medicine and surgery.

The Fortnight will present a carefully integrated program which will include clinics and clinical demonstrations at many of the hospitals of New York City, evening addresses, and appropriate exhibits. The evening sessions at the Academy will be addressed by recognized authorities in their special fields, drawn from leading medical centers of the United States. The comprehensive exhibit will include books and roentgenographs; pathological and research material; and clinical and laboratory diagnostic and therapeutic methods. It is also planned to provide demonstrations of exhibits.

The subject of the Fortnight will include the following:

- Historical sketch of the development of endocrinology
- Physiology of anterior lobe of pituitary gland
- Hyper and hypopituitarism
- Pituitary diencephalic syndromes
- Physiology of the ovaries
- Physiology of testes and therapeutic application of male sex hormones
- Puberty, menstruation and menopause
- Pregnancy
- Therapeutic application of female sex hormones
- Physiology of the parathyroid
- Hypo and hyper-parathyroidism
- The adrenal cortex
- The Cushing Syndrome: neoplasms of adrenal and their clinical relations
- Overfunctions of the adrenal cortex
- The adrenal medulla
- Adrenal insufficiency
- Relation of diabetes to endocrine system
- Relationship of endocrines to nervous system
- The physiology and principle inter-relations of the thyroid
- Hyperthyroidism and hypothyroidism
- Surgical treatment of hyperthyroidism and other diseases of the thyroid gland

The New York Academy of Medicine provides this program for the fundamental purpose of medical education. Consequently all members of the medical profession are eligible for registration.

### A COMPLETE PROGRAM AND REGISTRATION BLANK MAY BE SECURED BY ADDRESSING —

Dr. Mahlon Ashford

The New York Academy of Medicine  
 2 East 103 Street  
 New York City



## AMERICAN ASSOCIATION FOR THE STUDY OF GOITER

Cincinnati, Ohio

MAY 22, 23, 24, 1939

### Tentative Program

Monday, May 22

*Morning*

Surgical Problems of the Recurrent Goiter—

Dr. Ralph F. Bowers, New York, N. Y.

Metabolic disturbances Following Thyroidectomy—

Dr. Cleon Nafe, Indianapolis, Ind.

The Permanent Results Ten to Thirty Years After Thyroidectomy—Dr. Martin B. Tinker, Jr., Ithaca, N. Y.

Total Thyroidectomy for Diffuse Toxic Goiter—

Dr. Arthur C. Scott, Jr., Temple, Texas.

The Management of Severe Thyrotoxicosis—

Dr. W. O. Thompson, Chicago, Ill.

Surgical Treatment of Low Grade Hyperthyroidism—

Drs. Thomas O. Young and C. I. Krantz, Duluth, Minn.

*Afternoon*

Augmentation of Thyreotropic Hormone Activity by Adrenalin and Pilocarpine—Dr. Harry B. Friedgood, Boston, Mass.

Results of Further Studies on the Specific Metabolic Principle of the Pituitary Gland—Drs. J. B. Collip, A. H. Neufeld, O. F. Denstedt, Montreal, Canada.

Coronary Disease in Myxedema—

Dr. Elmer C. Bartels, Boston, Mass.

Psychiatric Aspects of the Borderline Thyroid Case—

Dr. J. M. Sartin, Springfield, Mo.

Goiter in the Deep South—

Dr. Howard R. Mahorner, New Orleans, La.

Study of the Influence of the Thyroid Gland on Intestinal Absorption—Drs. T. L. Althausen, Wm. J. Kerr, J. C. Lockart, and M. H. Soley, San Francisco, Cal.

*Evening*

A New and Function-Restoring Operation for Bilateral Abductor Cord Paralysis—Drs. Brien T. King and Frederick Lemere, Seattle, Wash.

Parathyroidectomy for the Calcinosis Syndrome—

Dr. Edwin G. Ramsdell, New York, N. Y.

Tuberculosis of the Thyroid Gland—

Dr. D. U. McGregor, Hamilton, Ontario

Tuesday, May 23

*Morning*

Dry Clinics—*Subjects to be announced*

*Afternoon*

Thyroidectomy by Electro-Surgery—

Dr. Arnold Jackson, Madison, Wis.

The Hippuric Acid Test in Hyperthyroidism—Drs. Samuel F. Haines, T. B. Magath and M. H. Power, Rochester, Minn.

The Blood Iodine Level in Thyroid Disease—

Dr. H. J. Perkins, Boston, Mass.

The Use of Vitamin B in the Management of Hyperthyroidism—Drs. W. D. Frazier and R. B. Brown, Philadelphia, Pa.

The Fate of Iodine in the Animal and Human Organism as Determined by the Distribution of Radioactive Isotopes of Iodine—Drs. S. Hertz, A. Roberts, R. D. Evans and J. H. Means, Boston, Mass.

Carcinoma of the Thyroid—Dr. T. C. Davison, Atlanta, Georgia.

Progressive Post-Operative Exophthalmos—

Dr. Lawrence P. Engel, Kansas City, Mo.

Some Clinical Observations on the Use of AT-10 in Parathyroid Tetany—Dr. E. Perry McCullagh, Cleveland, Ohio.

Van Meter Prize Essay

Wednesday, May 24

*Morning*

Operative Clinics in Cincinnati Hospitals

*Afternoon*

The Degenerating Thyroid and its effect upon the Heart  
Dr. Victor E. Chesky, Halstead, Kan.

Hyperthyroidism without Corroborative Laboratory Findings—Dr. Leon M. Bogart, Flint, Mich.

Papillary Tumors of Thyroid and Lateral Aberrant Thyroid Origin—Dr. George Crile, Jr., Cleveland, Ohio

The Preoperative Preparation of the Toxic Goiter Patient  
—Dr. Donald Guthrie, Sayre, Pa.

Anesthesia in Thyroidectomy with Special Reference to Avertin—Dr. Warren H. Cole, Chicago, Ill.

The Blood Pressure and Pulse Rate Changes During Anesthesia—Drs. Lindon Seed and Robbie Brunner, Chicago, Ill.

Carcinoma of the Thyroid Gland—

Dr. H. A. Gambel, Greenville, Miss.

The Management of Certain Types of Bad Risk Goiter Patients—Dr. Claud J. Hunt, Kansas City, Mo.

Electro-cardiographic Tracings in Thyroid Conditions—  
Dr. Frank Deneen, Bloomington, Ill.

Avertin Anesthesia for Thyrotoxicosis—

Drs. Elliott C. Cutler and Stanley O. Hoerr, Boston, Mass.

—☆☆—

## AMERICAN ASSOCIATION OF INDUSTRIAL PHYSICIANS AND SURGEONS

The 24th Annual meeting of the American Association of Industrial Physicians and Surgeons with the American Conference on Occupational Diseases and Industrial Hygiene will be held at the Hotel Statler, Cleveland, Ohio, June 5, 6, 7, and 8, 1939. A program of timely interest and importance will be presented by speakers of outstanding experience in all of the medical and engineering problems involved in industrial health. A cordial invitation is extended to all whose interest bring them in contact with these problems. Information regarding hotel accommodations, etc., may be obtained from A. G. PARK, Convention Manager, 540 North Michigan Avenue Chicago.

## • OBITUARIES •

### EDWARD GAGER FOX, M.D. 1859-1938

It having been the will of Almighty God to take from our midst Dr. Edward Gager Fox, we have the memory of a man who was skilled in the science of medicine but whose practice of the art of medicine was beyond that to be attained by most men. Dr. Fox was one to whom any man might turn for advice and comfort, these being given in a manner to make one feel that all things were for the best. Not always believing in all men and their ways, he never criticized adversely and was never unfriendly where unfriendliness would cause others to suffer.

Dr. Fox was born in Wethersfield August 8, 1859, the son of Dr. Roswell Fox and Ann Maria (Gager) Fox. He received his education in the public schools of that town and later attended the University of the City of New York, where he received his degree of M. D. in 1883. Dr. Fox then returned to Wethersfield where he established his practice which he continued to the time of his death, December 27, 1938.

Dr. Fox served as physician to the Connecticut State Prison from 1899 to 1919 when he retired from that position. He was Health Officer for the town of Wethersfield for many years until the time of his death and was also Medical Examiner over a long period. He was always much interested in civic affairs and held many positions of trust.

In 1892 he married Frances Stoddard Wells who survives him, as do also one son, Kenneth Lewis Fox, and two grandchildren.

We have lost a man, a counsellor and a much loved friend.

— James C. Wilson, M.D.



### ARTHUR WAYLAND HOWARD, M.D. 1867-1939

Arthur W. Howard died suddenly at his home in Wethersfield, Connecticut, on January 16th, 1939, bringing to a close a career of more than forty-nine years of medical practice.

Dr. Howard was born in Providence, R. I. in 1867, the son of Rev. Amasa and Anna (Simons) Howard. Coming to Hartford, Connecticut, he graduated from the Old South School and the Hartford High School. He attended New York University, graduating in 1890. Following graduation he established practice in East Hartford, but in less than a year moved to Wethersfield where he practiced until his death.

He was a member of the American Medical Association, the Hartford and Hartford County Medical Societies and the Connecticut State Medical Society. He was a member of Hospitality Lodge, AF & AM., and a member of the First Church of Christ, Congregational, in Wethersfield.

Dr. Howard was a member of the State Legislature in 1903. He took an active part in the work of the Wethersfield Business Men's and Civic Association. He was attending physician at the Newington Home for Crippled Children for several years, also at the State Institute for the Blind in Wethersfield.

Besides his wife, Hannah Standish Howard, he leaves a daughter, Professor Mildred Howard of Mt. Holyoke College, a son, Dr. Harold Howard, a sister, Mary Day Howard.

His whole hearted cheerfulness and generosity will be greatly missed by a large number of friends and patients, to many of whom he was benefactor as well as physician.

— Welles A. Standish, M.D.

## • Quarto Notes •

### THE INJECTION TREATMENT OF VARICOSE VEINS AND HEMORRHOIDS

H. O. McPheeters, M. D., F.A.C.S.

James Kerr Anderson, M. D., F.A.C.S.

315 pages

82 illustrations

\$4.50

Philadelphia

P. A. Davis Company

1938

This book includes two monographs either of which is well able to stand alone. It is true that both varicosities of the legs and hemorrhoids are dilated veins, and that both are in certain cases amenable to injection therapy; but there the comparison stops. The authors have therefore divided their book into two distinct treatises.



The first two-thirds of the volume, written by Dr. McPheeters, is devoted to the treatment of varicose veins. The anatomy and fundamental physiology and pathology are discussed. The indications and contra-indications for injection are taken up. Detailed directions concerning the type of sclerosing solutions and method of injections are given. The author prefers injections to ligation, but in some cases he feels that both are indicated.

The last third of the volume, by Dr. Anderson, is a succinct and accurate presentation of the injection treatment of hemorrhoids. The author states that about 25 per cent of hemorrhoids can be cured by injections alone, while 50 per cent. require injections followed by minor office surgery. The remaining 25 per cent. demand surgical excision. External and anal hemorrhoids should never be treated by injections. It is gratifying to note that the author is not an over ardent injection enthusiast. He feels that properly directed injection therapy has an important place in the treatment of hemorrhoids.

R. Starr Lampson

—☆☆—

## SURGICAL TREATMENT OF HAND AND FOREARM INFECTIONS

by

A. C. J. Brickel, A. B., M.D.

Department of Anatomy and Surgery

Western Reserve University

300 pages	166 text illustrations	35 plates
	\$7.50	
St. Louis	C. V. Mosby Co.,	1939

This book attempts to correlate the recent advances in the author's interpretation of the structure of the hand and forearm with the particular patterns exhibited by surgical infections in these parts and with the rationale of the surgical means employed to cure these infections and to minimize their results. One is reminded in reading this book of the pioneer work of Dr. Kanavel and comparison of treatment of infections of the hand and forearm now with the days of the World War is interesting.

In the present volume the reader is supplied with several plates portraying dissections and in addition roentgenograms made after the injection of opaque material. The most satisfactory opaque material was found to be 65 per cent barium sulphate in a mixture of acacia with a preservative added. A large bore needle, 18 or 20, bent at an angle of 25 degrees, a 20cc. lock tip syringe with finger holds were used. Two methods, open and closed, were followed out and the hand sometimes fleuroscoped

during the injection, or successive roentgenograms taken. The spread of this radiopaque substance injected throughout the various spaces of the hand simulates to a certain extent the behavior of collections of pus in cases of infection and indicates the intercommunications of the several structures and the possible pathways of inflammatory processes.

The author emphasizes several points worth noting.

(1) There is a common space between the carpal tunnel and the proximal end of the fibrous tendon sheaths concavity of the palm. This space extends from side to side so that it is possible to pass an instrument across the palmar floor underneath the fibrous tendons without encountering obstruction. Other authors have reported a separate mid palmar space.

(2) Every dressing of an injured finger should be accompanied by both passive and active motion to reduce disability and promote early restoration of function.

(3) Proper anesthesia, the proper location of incisions and physiotherapy are all important.

Special chapters are devoted to the treatment of osteomyelitis, to human bites, to the influences of diabetes and peripheral vascular disease upon infection and to the medicolegal aspects of hand injuries.

The closing sentence sounds a timely warning. "There is no such thing as a trivial cut or infection in the hand."

—☆☆—

## THE VAGINAL DIAPHRAGM Its Fitting and Use in Contraceptive Technique.

by LeMon Clark, M.S., M.D.

107 pages \$2.00

St. Louis C.V. Mosby Co. 1939

In spite of the utmost care exercised by physicians in instructing patients in the use of the vaginal diaphragm there is bound to be a small percentage of failures due to a break down in the human element rather than in the method. This volume is an excellent manual and should aid in reducing to a minimum this group of failures. In this volume the physician is impressed with the fact that he should properly instruct the patient so that she understands the method. He is also reminded that there is a proper size and type of diaphragm suited to the needs of each patient and that she should be drilled in the insertion and removal of the diaphragm until she can use it correctly.

The book is practical and explicit, is simple and well illustrated.

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(SEE PAGE 2.)

## COCXYGODYNIA

(Concluded from Page 232)

needed. The technique of massage was simply, with the finger as deeply as possible in the rectum, to press backward and lateralward with increasing force as the patient would tolerate it. Each treatment was more forceful and prolonged, care being taken never to give too much pain.

In severe cases, rectal heat with an Elliot machine was used, and during treatment the buttocks were strapped together with adhesive tape. This conversion of a female pelvis to a male one was sometimes a relief. The patient with the pain over the pudendal nerve distribution was injected with novocaine with a poor result, and I believe she should now have an alcohol injection of this nerve.

### Summary

Coccygodynia is a fairly common disease characterized by tenderness and spasm of the muscles about the coccyx which can be treated satisfactorily by massage given through the rectum.



## AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY COMMITTEE ON MATERNAL AND INFANT WELFARE

The American Congress on Obstetrics and Gynecology is sponsored by the American Committee on Maternal Welfare. This Committee is composed of member organizations with a representative from each, forming the Board. The member organizations includes the various national and sectional obstetrical and gynecological associations, hospital associations, public health organizations, and nursing associations.

The Central Association on Obstetrics and Gynecology proposed an American Congress on Obstetrics and Gynecology to study the present day problems on obstetrics and gynecology and their solution. The American Committee on Maternal Welfare was asked to sponsor this Congress. The Congress will be held in Cleveland, Ohio, September 11-15, 1939. The Committee expresses the purpose of the Congress, "To present a program of our present-day medical, nursing, and health problems, from a scientific, practical, educational, and economic viewpoint as far as they relate to human reproduction and

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maternal and neonatal care." This Congress is not in any sense a legislative body and naturally will take no action relative to maternal and infant care.

There will be sessions for each professional group in the morning with round table discussions. The afternoon meetings will have papers of general interest to all members attending the Congress. The public will be invited to the evening sessions where there will be speakers of national prominence.

The program for the physicians will include among many others such subjects as pregnancy associated with: thyroid disease, heart disease, diabetes, tuberculosis, nutritional factors, carcinoma of the female genitive tract, and abortions.

The Congress is not planned as a meeting for specialists in any sense of the word but for all physicians who are interested in the problem of maternal and child welfare. Your Committee highly recommends this Congress as a week of postgraduate work which should be worth while much more to the physician than the time and expense incurred for the trip. The physicians of

this state should be well represented at this Congress.

The membership fee of \$5.00 includes membership in The American Committee on Maternal Welfare and registration in The American Congress on Obstetrics and Gynecology. Application blanks and further information may be secured from your chairman, Dr. Joseph H. Howard, Bridgeport, or from The American Congress on Obstetrics and Gynecology, 650 Rush Street, Chicago, Illinois.



### EIGHTEENTH ANNUAL COMPILATION OF HOSPITAL DATA PUBLISHED

The eighteenth annual presentation of hospital data by the Council on Medical Education and Hospitals of the American Medical Association, published in *The Journal* of the Association for March 11, shows that a number of records in hospital service were broken in 1938.

For the first time in eight years the number of registered hospitals increased over that of previous year; births in hospitals passed the million mark; the number of beds increased 36,832 as

compared with the average annual increase of 24,677 beds for the previous thirty years. In 1938 hospitals admitted patients at the rate of one every 3.3 seconds.

The report lists 6,166 registered hospitals having a total of 1,161,380 beds, 56,747 bassinets, 1,026,771 births, an average census of 965,706, with 9,421,075 patients admitted. In addition, there are 136 hospitals opened and their registration pending, sixty-seven under construction and 185 planned and being developed.

Supplementary to these facilities there are 2,529 institutions, emergency stations, clinics and cottages designed to give emergency and other auxiliary types of hospital and medical care of which the Council on Medical Education and Hospitals has record.

The rate of growth in registered hospitals is equivalent to one hospital of 101 beds for each day in the year, Sundays and holidays included.

Details in the report of bed occupancy shows an average of 195,674 idle beds during the year whereas in recent years the average had been 180,000. In general hospitals there were 132,454 idle beds as compared with 123,811 in the preceding year. Even in nervous and mental hospitals the average number of empty beds increased during the year from 23,710 to 29,485, although need for more mental hospital facilities is obvious in most states. Idle beds in tuberculosis hospitals were reduced from 11,951 to 9,780. The average number of unoccupied beds in governmental hospitals for the year was 78,449, a considerable increase over 69,869 for the previous year. The idle beds in all non-governmental hospitals averaged 117,225.

Particularly striking is the increasing rapidity of turnover. Each year the average length of stay, particularly in general hospitals, is clipped shorter and shorter, now being twelve and one-half days.



#### DR. KARSNER FETED ON BIRTHDAY

In recognition of Dr. Howard T. Karsner's sixtieth birthday, January 6, and the completion of his twenty-fifth year as professor of pathology at Western Reserve University School of Medicine, former students, assistants, colleagues and friends presented him with an oil portrait of himself at a tea held in the Institute of Path-

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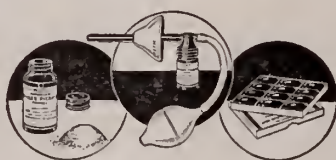
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ology. On the same day at a luncheon held at the Cleveland Club, his colleagues on the faculty of medicine presented him with a signed scroll.

— *Ohio State Med. Jour.*, Feb. 1939

(Ed. Note) Dr. Karsner may be recalled by many as Assistant Professor of Pathology, Harvard Medical School, in the days of Dr. William Councilman.



## EPINEPHRINE IN OIL ANNOUNCED BY SQUIBB

Epinephrine in Oil, as developed by Dr. Edmund L. Keeney of Johns Hopkins Medical School and Hospital, was placed on the market April 1 by E. R. Squibb & Sons. This preparation is a suspension of powdered epinephrine crystals in peanut oil, in the proportion of 2 mg. in each 1 cc., resulting in a dosage form of epinephrine that has a more prolonged effect than the usual aqueous solution of epinephrine hydrochloride.

## TELEPHONE LISTING

In the telephone directories of the Southern Bell Telephone and Telegraph Company for Florida, the classified section shows medical doctors with the suffix "M.D." In the alphabetical list the suffix "Dr. Phys." is shown after each medical doctor's name.

Other practitioners of the healing art in Florida are listed under different symbols. The public now when referring to telephone directories will be able to select its doctors more intelligently. — *Jour. Fla. Med. Assoc.* Feb. 1939.



## THE DRUGGISTS' CAMPAIGN

Again we commend the West Virginia Pharmaceutical Association on its campaign to restore the old art of prescription writing. Most members of the Association have received their monthly releases suggesting the use of USP preparations instead of proprietary medicines. The purpose of the campaign is to ease the pressure on the patients' pocketbook, an item of no small consideration to the medical profession in this changing economic era. — *W. Va. Med. Jour.*, Feb. 1939.

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## DIAGNOSIS AND INCIDENCE OF VITAMIN A DEFICIENCIES

(Concluded from Page 223)

that there is little evidence of a high incidence of sub-clinical dietary avitaminosis-A among ordinarily healthy people. With dietary habits common to our population, an individual does not easily reduce his vitamin A consumption to a critical value, except under special circumstances. The other thing is that when made under carefully controlled and specified conditions, measurements of dark adaptation may be used as a diagnostic sign of a decreased vitamin A supply to the retina long before the appearance of clinically recognizable symptoms. Further signs must then be relied on to designate this lack as due either to a deficiency in the diet, or to a pathological disturbance in the vitamin path in the body.

—☆☆—

## HOW TOWNS CAN ORGANIZE FOR HEALTH

(Continued from Page 244)

Factor of Social Security." Am. J. of P. H., 27, 1079, November, 1937.

Newsholme, Sir Arthur. "The Health Department in the Field of Medicine — From the Standpoint of Experience in England." Am. J. of P. H., 27, 1089, November, 1937.

United States Public Health Service. "Extent of Rural Health Service in the United States, December 31, 1932 to December 31, 1936." Public Health Reports, 52, 1639, November 19, 1937.

—☆☆—

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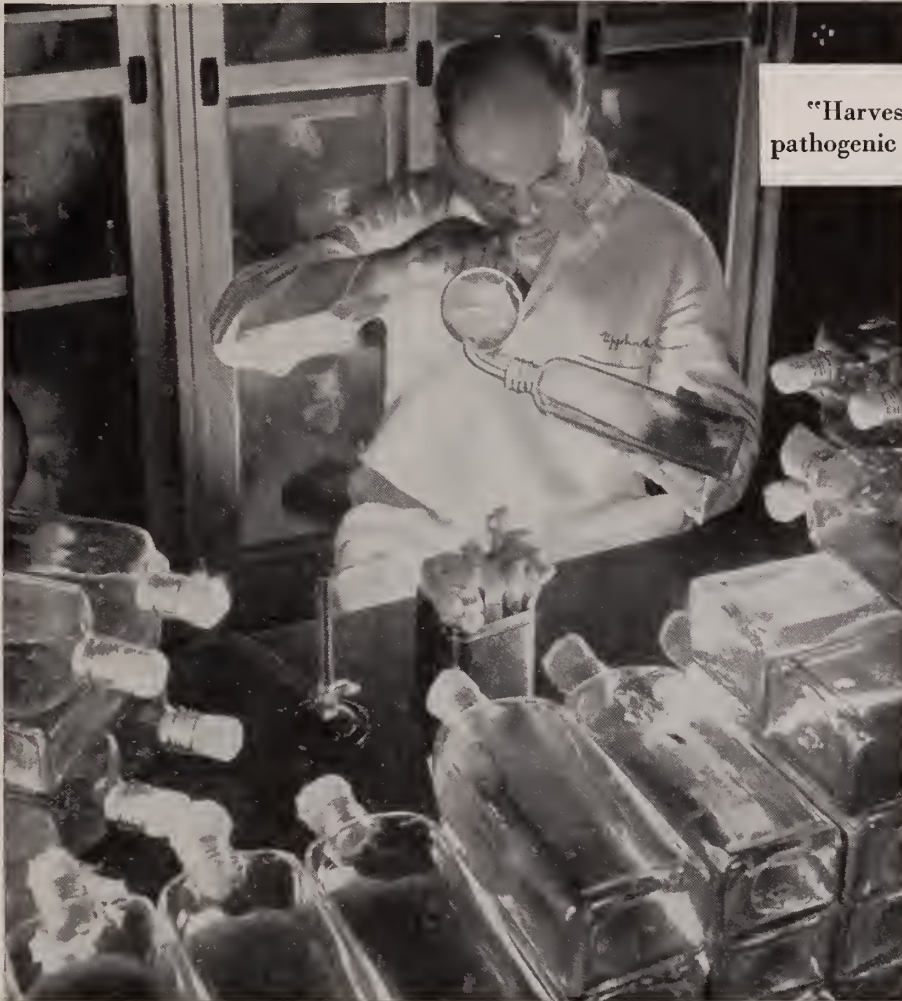




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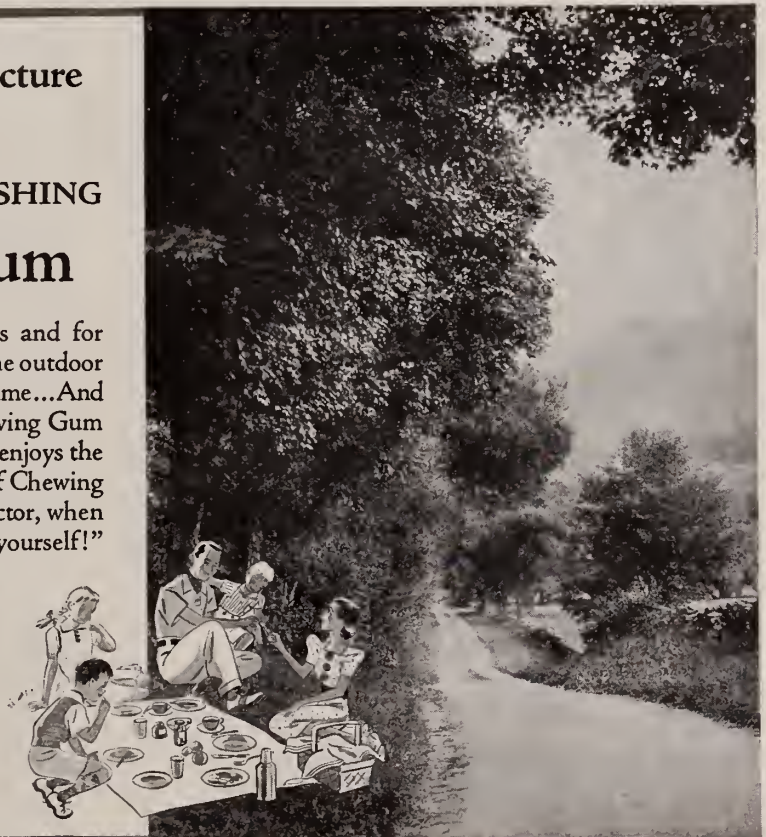
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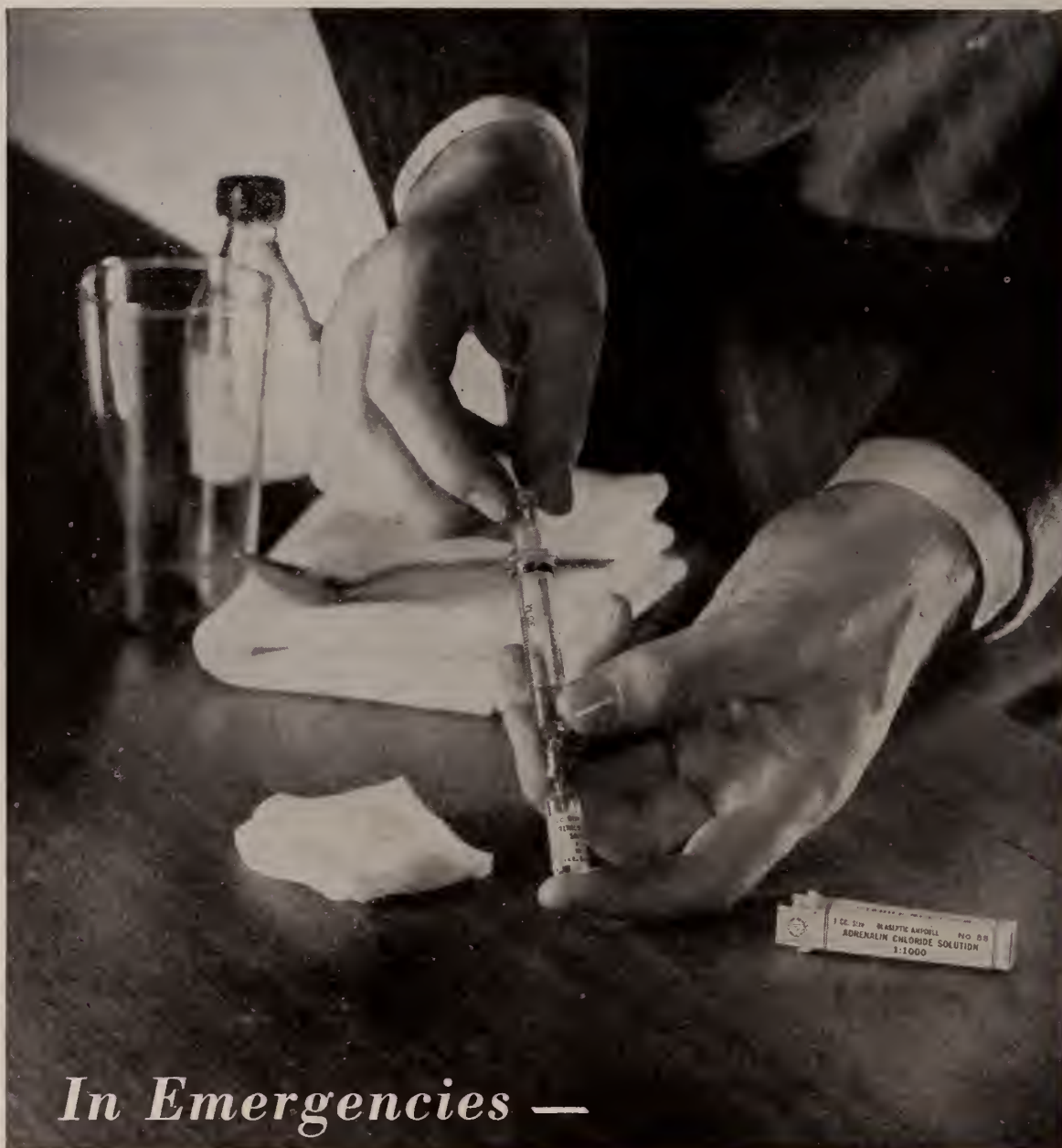
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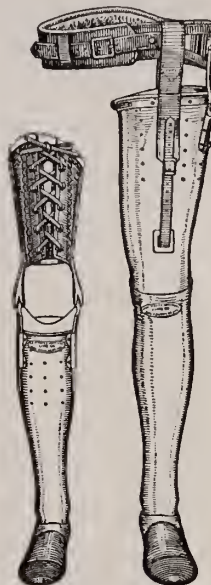
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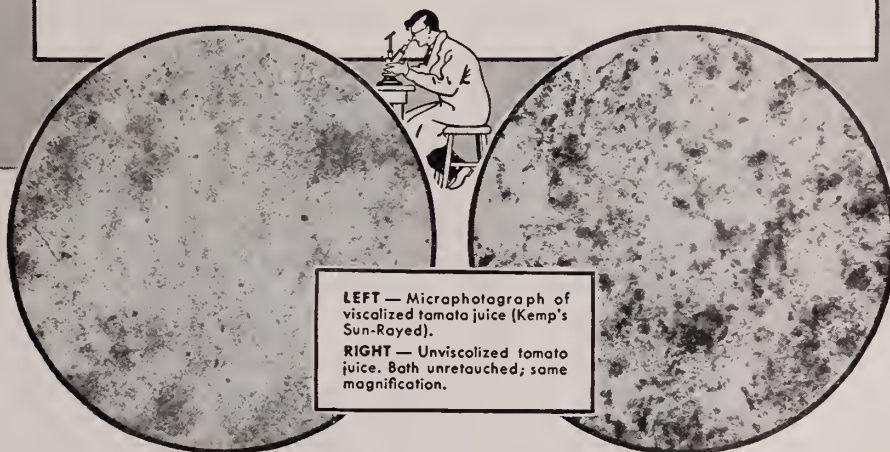
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\*Further Clinical Observations on Feeding Infants Whole Milk, Gelatinized Milk, and Acidified Milk. C. Loring Joslin, M.D., F.A.A.P.; Bulletin of the School of Medicine, University of Maryland; Jan. 1939.

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Graduate Yale University School of Medicine 1908  
Fellow American College of Physicians  
Health Officer  
City of New Haven





JOSEPH I. LINDE

## *MESSAGE FROM THE PRESIDENT*

A year of apprenticeship for the position with which I have been honored and several years of service on your Public Health Committee have impressed me with the progressive spirit of the Connecticut State Medical Society.

Its interest and active participation in the Maternal, Child Health, Crippled Children's, Cancer Control and Mental Hygiene programs of the state and the activities of its Public Health, Tumor, Industrial Hygiene and other Committees, are examples of its attitude toward the newer trends in public health.

This progressiveness has been wisely stabilized by the experience and rich tradition of almost 150 years of successful existence, during which time its members have served the state and their communities with one interest — the health of the people.

The membership of the Society has faced and enthusiastically accepted the great scientific developments which have resulted from research and are incorporated in the practice of modern medicine. It must and will continue to use new proven methods.

The Society now faces the possibility of changes and developments in relationships and in the administrative fields of practice. Great problems have been placed before the profession by the proposals for these changes, which must be considered calmly, deliberately, with the spirit of progressiveness that has always pervaded the Society and in the light of past experience and tradition.

All members must consider in harmony the great problems with which the Society is now and may in the near future be confronted.

JOSEPH I. LINDE, M.D.

# JOURNAL *of* The Connecticut State Medical Society

VOL. III.

JUNE, 1939

No. 6

## The Surgical Treatment of Hypertension Observations—38 Patients Selected for Surgical Therapy\*

FRANK GLENN, M.D.

From the Department of Surgery of the New York Hospital  
and Cornell University Medical College

For a period of slightly over five years, the Department of the New York Hospital and Cornell Medical College has been carrying on a closely regulated study of the surgical treatment of hypertension. Doctor Heuer and his staff were for a period of almost four years in close collaboration in this pursuit with Doctor Irvine H. Page of the Rockefeller Hospital, and during this period of time, the patients were studied intensively in the Rockefeller Hospital and selected from there for operation at the New York Hospital. Almost a year ago, Doctor Page left New York and began work in Indianapolis, and we have continued this study in the New York Hospital.

Three types of operations have been employed. They are: (1) Rhizotomy, or Division of the Anterior Nerve Roots of the Spinal Cord, (from  $D^6$  to  $L^2$ ), (2) Supradiaphragmatic Resection of the Splanchnic Nerves Combined with Lower Dorsal Ganglionectomy, and (3) Subdiaphragmatic Resection of the Splanchnic Nerves Combined with Removal of the 1st and 3rd Lumbar Sympathetic Ganglia.

A summary of our experience with these three procedures follows.

### **Rhizotomy, or Division of the Anterior Nerve Roots of the Spinal Cord.**

21 patients were selected as suitable for this operation, one died at the completion of the operation, and one died several days after operation; one recovered from the first stage but refused to permit the second stage. One patient, after the first stage showed signs of a transverse lesion of the cord but when, eight days later, his dura was

opened widely a recognizable lesion of the cord could not be demonstrated. There remain, then, seventeen patients in whom the operation was completed. In summary of this group one may say that in early mild hypertension in young women, four of six patients have had a satisfactory reduction in blood pressure and relief of subjective symptoms for almost 3 years. Two of these six patients have had complete relief of subjective symptoms; are in good health and doing their usual work twenty-six and twenty-eight months after operation; but their blood pressures, after being reduced satisfactorily for nine and fifteen months, have again risen to approximately pre-operative levels.

In severe benign hypertension, three patients show a slight but an unsatisfactory reduction in blood pressure. They show, however, marked subjective and objective improvement at the end of 10 to 23 months. In severe benign hypertension with marked vascular changes, one of three patients has had a fairly satisfactory reduction in blood pressure for 26 months and is in good physical condition with a minimum of subjective symptoms. Two of three patients showed a definite reduction of blood pressure but died of the disease 16 and 9 months respectively after operation. The relief of subjective symptoms was striking and one led an active life for over a year after operation.

In severe malignant hypertension, one of five patients has had a satisfactory reduction in blood pressure and he leads an active normal life two years after operation. One had a considerable

\*Read at the 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.



reduction in blood pressure for seven months, but at the end of fifteen months his systolic pressure nearly equals his pre-operative pressure, while his diastolic pressure remains satisfactorily reduced. He is greatly improved. Three of the five patients died—one immediately after operation, one two months after operation and one ten months after operation.

### Summary

It is therefore apparent that all the effects of anterior root section upon hypertension are not permanent. There is manifested in some cases a tendency for the blood pressure to return to the pre-operative level over a period of 2-3 years. The subjective and some of the objective manifestations of the disease appear to be more definitely relieved; for scarcely without exception in our experience has anterior root section been followed by striking improvement in headaches and other subjective symptoms of the condition. Likewise, the disappearance of papilledema and hemorrhage and even the less marked eyeground changes have been observed.

### Supradiaphragmatic Resection of the Splanchnic Nerves Combined with Lower Dorsal Ganglionectomy.

1. Supradiaphragmatic splanchnic nerve resection with the interruption of the thoracic sympathetic chain was performed in 9 patients. Six of them were cases of essential hypertension varying in severity from mild to severe and in age from 25-48 years. Of the other three, one (aged 25) suffered from early malignant hypertension, and the remaining two (aged 18 and 25) from malignant hypertension.

2. Supradiaphragmatic splanchnic nerve resection was well borne in all patients and there have been no complications or fatalities. We have been unable to detect that the patients have been harmed by the operation. The reduction in arterial pressure which occurred following operation was marked but within 6 months it had returned to the pre-operative level in all patients. Subjective improvement consisting of lessening in frequency and severity of headaches, ease of fatigue, nervousness, tenseness and irritability occurred in 6 of the patients with essential hypertension, but in 3 improvement lasted less than a year. Improvement in those with malignant hypertension was transient.

3. Renal efficiency was unaffected by the operation. It also appeared to have no marked effect on the heart as judged by electrocardiographic records or Roentgen ray photographs.

Reduction in intensity of the constriction in retinal arterioles occurred in all of the cases except one with malignant hypertension demonstrating that arteriolar relaxation occurs in regions other than those denervated. In most of the patients constriction has returned after several months.

### Subdiaphragmatic Resection of the Splanchnic Nerves Combined with Removal of the 1st and 3rd Lumbar Sympathetic Ganglia

1. Subdiaphragmatic Splanchnic Nerve Resection with interruption of the lumbar sympathetic chain was performed in 8 patients. Six were patients with essential hypertension varying in severity from mild to severe, and in age from 27-47. Two suffered from severe malignant hypertension, (age 46-36).

2. Subdiaphragmatic splanchnic nerve resection was well borne in all patients. One patient with severe malignant hypertension died 10 days after operation in uremia. Another with malignant hypertension had only transient improvement. One patient refused the second operation. The reduction of the blood pressure which occurred following the operation was marked but tended to return to the pre-operative level within a period of six months.

There was subjective improvement in the six patients with essential hypertension consisting of lessening in frequency and severity of headaches, ease of fatigue, nervousness, tenseness and irritability.

3. The renal efficiency was unaffected by the operation as indicated by urinary findings and the urea clearance test. Four patients complaining of nocturia of 3-4 times, noted a lessening or disappearance of this. The heart has not been observed to undergo any effects as determined by electrocardiographic records or Roentgen ray examination. Reduction in intensity of constriction of the retinal arterioles has occurred in all patients whose pressure has been lowered. With a reelevation of the blood pressure, three of these patients failed to exhibit a return of the constriction.

It is evident from the foregoing summaries of the results obtained from the three surgical methods employed by us in the treatment of hypertension that definite and dogmatic statements cannot be made. In this series of 38 patients selected for surgical treatment, we have observed clinical improvement in a great proportion.

(Continued on Page 323)

## The Use of Drugs in the Treatment of Essential Hypertension\*

DAVID AYMAN, M.D.

Boston, Mass,

The use of drugs in the treatment of essential hypertension is directed (1) to the relief of symptoms and (2) to the lowering of the elevated blood pressure. However, the relief of symptoms may often be obtained without a lowering of the blood pressure, and conversely, the blood pressure may be lowered without relief of symptoms. I think, therefore, it is best to discuss the treatment of the symptoms apart from the attempt to lower the blood pressure.

The symptoms associated with essential hypertension may be divided into two groups, the early and the late group of symptoms. The late group of complaints such as shortness of breath, nocturia, angina pectoris, paralyses and difficulties in vision, are due to severe vascular damage.

The early symptoms are found in the absence of demonstrable disease of the ocular fundi, heart and kidneys. They may recur for years and later co-exist with the late symptoms. In previous studies we have shown that the early symptoms are probably of spastic and psychoneurotic origin. These early symptoms include flushing, cold hands and feet, dizziness, headaches, weakness, palpitation, sweating, insomnia and irritability. These early so-called hypertensive symptoms have been treated in the past by dozens of different drugs. The amusing fact is that nearly everybody has reported great success along these lines. The most recent report is that even when the surgical operation of splanchnic resection does not cure the blood pressure, it, nevertheless, almost invariably produces dramatic relief of symptoms. This universal success in the treatment of symptoms suggests that the common factor in all these drugs or methods is the enthusiastic giving or doing of something to the patient. It is "treatment" regardless of its nature.

Sometime ago, I found that when I prescribed

deliberately with enthusiasm a placebo of a few drops of dilute hydrochloric acid daily to a group of 40 patients with essential hypertension, I obtained 82% improvement in their symptoms. I even obtained several reactions with this placebo which again is so like the results obtained by various drugs reported in the literature. It becomes clear, therefore, that when you find any report in the literature referring to the relief of symptoms in essential hypertension, especially where there has been no effect on the blood pressure, one should be extremely critical.

These early symptoms of spastic and psychoneurotic origin, which may last for years, can be relieved by the suggestion inherent in any enthusiastically given drug, by the use of sedatives, by physical and mental relaxation and by direct psychotherapy. The best drugs are the simple sedatives such as phenobarbital and sodium bromide given in adequate doses for weeks at a time.

If we turn to the drug treatment directed to the lowering of the blood pressure, we must be just as critical. It is clear that at present there is no specific drug or method that cures essential hypertension. I know that many of you could report apparent cures of blood pressure by various drugs or methods. However, I would like to point out various fallacies of observation that give rise to these apparent but unreal successes. These errors of interpretation are due to mistakes in the control study before giving the drugs. One must recognize that the blood pressure in essential hypertension has great variability from minute to minute. This is dependent on the unknown variations of the disease itself and also upon the effect of the environment on the patient. Before the effect of any drug is evaluated you must have an adequately long control period of blood pressure readings using preferably some placebo during this period of

\*Read before the 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.



control. The blood pressure readings during the control period should be taken in the same careful way as during drug therapy. Another factor regularly overlooked is the effect of the frequency of visits to the doctor on the blood pressure level. I have found that the more frequent the visits to the doctor, the lower will the level of blood pressure be found, without any treatment. This, of course, is due to the greater relaxation of the patient, the more often he comes. The hypertensive patient is notoriously of the high-strung energetic type and, therefore, the more often he comes to your office, the more relaxed he becomes. Therefore, the control period before the drug should have a similar frequency of visits as during drug treatment. Finally, the minimum drop in blood pressure that may be evaluated is at least 30 mm. systolic, even with use of all those methods of control. In the past year I have added one more control method, namely, I have given a small select group of patients with essential hypertension a blood pressure machine and stethoscope and taught them to take their own blood pressure twice a day. This has given us the greatest information and control.

Using these different methods of control, I have studied during the past ten years the effect of many of the numerous drugs reported as effective. I have found potassium iodide without the slightest effect upon the blood pressure level despite its age-old usage. In view of the possible relationship of the menopause and ovaries to essential hypertension I have used the ovarian estrogenic hormone by injection in large doses without any effect. Bismuth subnitrate has been given widely to lower blood pressure but I have found it of no value after giving as long as six months. Potassium sulphocyanate has been used since 1903 and it must be admitted that this drug has a definite hypotensive effect. However it is so toxic that I consider it very unwise to use it unless one can obtain at least weekly blood cyanate determinations. For general practice, therefore, it is dangerous. Dr.

Soma Weiss has shown that the arterioles in essential hypertension are the chief seat of the constriction causing the rise in blood pressure. Therefore, it is reasonable that the vasodilator nitrites should be tried. Here again, the nitrites definitely lower blood pressure but only in a transient way. Further, in a very high percentage of cases their use is followed by very severe headache. This leaves us with the sedatives as a means of lowering blood pressure. If, for example sodium amytal or sodium pentothal are given by mouth or intravenously to patients with essential hypertension until they are so soundly asleep that they do not awake while the blood pressure is being taken, one finds often that even with levels such as 260/140, that the blood pressure drops not infrequently to normal. Such results are challenging in the sense that they indicate the possibility that the blood pressure can be lowered. However, the dosage of sedatives ordinarily used does not produce more than slight drowsiness and, therefore, does not lower blood pressure more than a minimal amount. Their greatest effects are upon the symptoms.

It is obvious, therefore, that the definition of essential hypertension is still that of a disease of unknown etiology and unsatisfactory treatment.



#### AMERICAN PUBLIC HEALTH ASSOCIATION QUALIFICATION REPORT

The American Public Health Association has recently adopted five Reports dealing with Educational qualifications of Public Health Statisticians, School Health Educators, Public Health Engineers, Sanitarians, and Sub-Professional Field Personnel in Sanitation. These Reports are distributed free of charge in the hope that they will serve a useful purpose in raising the educational standards of professional public health personnel. Copies may be secured from the Book Service, American Public Health Association, 50 West 50th Street, New York, N.Y.

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(SEE PAGE 2.)



# Results from Colloidal Aluminum Hydroxide in Peptic Ulcer Therapy:

An 18 Months Survey at the Hartford Hospital, Hartford, Conn.

BENJAMIN B. WHITCOMB, M.D.  
New Haven, Conn.

During the past few years colloidal aluminum hydroxide has become an important therapeutic agent in the medical management of peptic ulcer. Einsel, Rowland and their associates have demonstrated the efficacy of an amphoteric colloidal suspension of aluminum hydroxide as an antacid, astringent and demulcent which is not absorbed through the gut and is apparently harmless in its gastrointestinal action.

Since the introduction of this form of therapy for peptic ulcer at the Hartford Hospital,\* a clinical study has been made comparing its results with those of other methods of medical management which have been used over the same period, chiefly the Sippy regime. In this review — of the 238 admissions for peptic ulcer — 104 cases were found suitable for comparison since they met the necessary requirements of (1) having x-rayed evidence of ulcer and (2) having followed a prescribed course of medical treatment under hospital observation.

Of the 104 cases selected 50 were treated with colloidal aluminum hydroxide, 45 were on the Sippy regime and 9 were treated by various other medical methods. Ten of the patients who received colloidal aluminum hydroxide were treated by the constant drip method as described by Woldman and Rowland. Since this method has been strongly advocated to promote more rapid healing, these have been compared separately. The basis for selecting the particular type of therapy for a given case was influenced in no way by the type, duration or severity of the ulcer but resolved principally to the fancy of the attending physician or house officer in charge, while on some services the method of alternating the type of therapy with successive admissions was used.

The comparison in the results of the different regimes may be seen in the accompanying table. This comparison is based on the rapidity and permanence of healing, and the percentage of

\*Period of survey: September 1936 to March 1938.

Type of Treatment	Number of Patients	Average Number of Hospital Days	Number having X-ray Re-examination	Number showing Improve- ments to X-ray	Per cent showing Improve- ment to X-ray	Average Interval in days between X-rays	Patients returned because of failure during review	Per cent of failures	Failure to control symptoms	Per cent of failures symptomatically
Aluminum Hydroxide Drip Method	10	13.6	10	8	80.	20	0	0	0	0
Aluminum Hydroxide Oral Use	40	17.5	16	13	81.25	26	0	0	2	5
Sippy Regime	45	28.9	25	11	44.	50	6	13.5	9	20
Other Methods	9	29.	5	0	0	80	1	11	2	22

symptomatic and x-ray cures found in each method. Other features for comparison will be mentioned although not included in the table.

These results demonstrate that, when compared with the Sippy regime, the use of colloidal aluminum hydroxide materially reduced the length of hospitalization for peptic ulcer making a saving in this series of 560 hospital days. It promoted a more rapid and definite healing process as demonstrated by x-ray findings, symptomatic relief and lack of recurrences. This latter feature may be due in a large part to the simplicity of this method of treatment which is an advantage over the more detailed Sippy regime and therefore more likely to be followed after the patient has been discharged. Some further advantages which have been noted in this review are the increased activity permitted during treatment and the wider latitude in diet, which permits the free use of essential foods necessary for general debility or the use of special diets for other complicating diseases.

Of the patients treated with colloidal aluminum hydroxide, healing could be demonstrated by x-ray at an earlier date in those receiving the constant drip method — usually within two weeks. Many cases in this review, however, showed marked improvement, or complete healing, in less than 3 weeks when the gel was taken by mouth. The constant drip method appeared more effective in those cases having a high acid curve — here the acid fixation is more constant and thorough and the results, therefore, are usually more satisfactory. This method was also preferred in the refractory cases and with those patients whose condition required more drastic methods — as in one case showing, by x-ray, a chronically indurated post pyloric ulcer with a marked obstruction and twenty-four hour residue. Here the constant drip method was employed for 10 days after which the gel was given by mouth. Vomiting and nausea ceased on the second day; liquids were started on the third day and increased as tolerated. The patient was discharged on the 18th day, and x-rays after an interim of four weeks showed marked improvement and no evidence of obstruction. Other than such stubborn cases the advantages in the drip method of shortening the healing time a few days does not outweigh the discomfort of the constant presence of an inlying Levine or Woldman tube.

In twenty-one of the admissions reviewed symptoms were not relieved by Sippy treatment — some of these cases went to surgery; some returned to begin the Sippy regime anew while nine were subsequently given aluminum hydroxide with prompt relief of symptoms. In another case of Sippy failure, aluminum hydroxide therapy, strictly followed for one week, also failed to relieve severe pyrosis following several hemorrhages. This case then went to surgery where a pylorotomy and gastro-enterostomy were performed; the symptoms, however, still persisted when the patient returned to the follow-up clinic. (This represents the only case of this series which has gone on to surgery following failure to control symptoms by colloidal aluminum hydroxide.) One other case in which aluminum hydroxide failed to completely control symptoms was found and in this case definite improvement was seen. It might be stated here that seven of the cases which were treated effectively by aluminum hydroxide were recurrences following surgery.

The methods of treatment with colloidal aluminum hydroxide used in this series varied somewhat in details — on the different services — but the principles were the same. In using the constant drip method, as described by Woldman, an air-tight apparatus permitted the flow of a twenty-five per cent mixture of the colloidal cream of aluminum hydroxide in water to pass through a Levine tube into the stomach. This was done by displacing air into the aluminum hydroxide reservoir by a slow dripping of water into the air-tight apparatus. The Levine tube was passed through the nose and left in place for about 10 days. The diet in the uncomplicated case was an ordinary bland or smooth diet; but this was varied in severe cases to 2-hour feedings of milk, fruit juices, et cetera.

When aluminum hydroxide was given by mouth it was usually prescribed in dosage of drachms 1 or 2 in  $\frac{1}{2}$  glass of milk or water to be taken at some given time between meal-time and 2 hours post cibum. One method of use was to substitute this dosage for the powders in the Sippy regime. The most common routine, however, was to give 1 drachm of the 7% stock colloidal cream of aluminum hydroxide in milk every two hours during the day and twice during the night — usually at 2 and 5 A.M. A bland diet was usually allowed. On discharge 6 meals a day, each followed by aluminum hydroxide in



above doses and twice during the night, were advised. The constipating action of colloidal aluminum hydroxide was its chief disadvantage, but this was easily controlled in the average bed-case by mineral oil while little or nothing was required for the ambulant patient. Although the action of colloidal aluminum hydroxide in the treatment of peptic ulcer depends chiefly on its properties as an antacid, the astringent and protective qualities are also important. As evidence of this fact, several of the cases of this series showing achlorhydria displayed rapid improvement with the use of aluminum hydroxide.

### Summary

In an attempt to evaluate the benefits of colloidal aluminum hydroxide therapy in peptic ulcers and compare the results with those of other familiar methods, a review has been made of 104 cases of peptic ulcer receiving adequate medical investigation and treatment at the Hartford Hospital for the 18 months following the introduction of aluminum hydroxide. Nearly an equal number was found treated with aluminum hydroxide as with the Sippy regime. The following results were observed: the average number of hospital days for those treated by aluminum hydroxide was little more than one-half that required by the Sippy regime, while the per cent improved by x-ray was nearly twice that of the Sippy regime — even though the x-ray examination was made after a much shorter interval. There were no recurrences in the cases treated by aluminum hydroxide; on the other hand 13.5% of the Sippy cases in this series already have returned because of failure. The failure to control symptoms during treatment was four times as great among those on the Sippy regime.

The economic and clinical and chemical advantages of colloidal aluminum hydroxide over other medical forms of treatment have been suggested. It has been further shown that the constant drip method of aluminum hydroxide therapy was only slightly more effective than its oral use and therefore should be reserved for selected cases. The method of treatment in

each case has been described. Rapid healing in those cases showing achlorhydria suggest that the astringent and demulcent properties of aluminum hydroxide are important factors in the healing of ulcers.

Note: We are indebted to the Cleveland Chemical Co. and the Alba Chemical Co. for supplying the aluminum hydroxide gel to the ward patients during this survey.

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### Erratum

In Volume III, Number 4, issue of the Journal for April 1939, page 172, in an article by Grover Powers, M.D., on "Sulfanilamide in Pediatrics" the dosage table used at the New Haven Hospital is incorrect as it appears. It should read as follows:—

For children under 6 months —  $1.5 \pm 0.5$  gr/lb

For children over 6 months —  $1.25 \pm 0.25$  gr/lb

For children over 6 years —  $1.00 \pm 0.25$  gr/lb

—☆☆—

### NEW ENGLAND SOCIETY OF PSYCHIATRY

The New England Society of Psychiatry held its 64th annual meeting recently at the Metropolitan State Hospital, Waltham, Massachusetts, as the guest of Superintendent Roy D. Halloran. 169 members and guests attended. Among those elected to full membership was Paul R. Felt, M.D., Middletown, Connecticut. One of the Annual Awards for the best papers published during the calendar year of 1938 was given on the recommendation of the Special Examining Committee on Annual Awards to Stanley R. Dean, M.D., Fairfield, Connecticut. The subject of Dr. Dean's paper was "Studies in Convulsant Therapy: 1. Technique and Clinical Phenomena; 2. The Role of Alkalinization." The first section of this paper appeared in a previous issue of the JOURNAL. George A. Elliott, M. D., Middletown, Connecticut, was elected Secretary-Treasurer for the ensuing year.

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# The U Wave of the Human Electrocardiogram\*

LOUIS H. NAHUM, M.D.  
New Haven, Conn.

Whenever we now receive a report of an electrocardiogram we have an accurate description of the auricular complex P and of the ventricular complex Q R S T in the various leads. It is probable that in the future to this will be added also the U wave. Following the T wave of the human electrocardiogram is a small summit varying in amplitude from  $\frac{1}{4}$  to 1 millimeter, and extending for .16 to .24 of a second. It is most prominent in Lead IV and extends usually in the same direction as T. In reading electrocardiograms this wave is never mentioned and its occasional distortion of T is not appreciated. This wave, however, was recognized by Einthoven, who invented the electrocardiograph, and by Lewis and Gilder. Its significance was not understood and it disappeared from the literature after Hering in 1909 offered the opinion that it was not related to cardiac contraction but originated from action currents produced by the great vessels.

The first question to answer was whether this wave is an artefact of recording. We think not because it appears in records taken by the string galvanometer as well as by tube amplification instruments. Furthermore, in some animals, like the dog, it is not often seen normally but may be readily revealed by some experimental condition like intra-venous calcium injection.

We undertook to determine whether the U is actually a part of the ventricular complex. To do this, induction shocks were applied to the surface of the ventricle of a cat and the refractory period analyzed. It was found that under certain conditions a supernormal period of excitation occurred at the terminal portion of T, or on a U wave when it was present. This indicated that electrical effects of systole were still present at this point, and therefore that the U was actually a part of the ventricular complex.

If it is a part of the ventricular complex a study of it should give information not now available. We therefore analyzed over 500 electrocardiograms and found that an appreciable U wave

occurs in over 75% of normal records, especially in Lead IV, whereas in abnormal electrocardiograms only 40% showed a U wave. Stated, in another way, when the U wave is absent in Lead IV the patient should be studied more closely for signs of heart disease. Usually the U follows the same direction as the T wave. However, occasionally we found the U oppositely directed to the T.

Once we learned to recognize it, certain abnormalities of T were revealed. The most distinctive one being a widening of T because of the fusion of T and U. Why this occurs is not yet clear, but thus far it was observed only in records of damaged hearts.

One striking fact which the study of the U wave uncovered, was the association of this summit with the occurrence of extra-systoles. We plotted 431 ventricular extra-systoles as regards their point of occurrence and found the vast majority to fall somewhere on the U wave. This relationship can hardly be accidental. It would seem that the mechanism of most of the extra-systoles is related in some way to the chemical processes occurring in the heart during the period of the U wave. We have already seen that at this point a super-normal period of excitation may exist. We hope that further study will throw additional light upon the meaning of extra-systole.

## Summary

1. The U wave should be added to a reading of the human electrocardiogram.
2. It is a part of the ventricular complex.
3. It occurs in 75% of normal records, especially in Lead IV.
4. It occurs in only 40% of records of diseased hearts.
5. Its direction is the same as T, but occasionally it is oppositely directed.
6. It may distort the T wave and this is found only in records of diseased hearts.
7. It is the commonest site for the occurrence of ventricular extra-systoles.

\*Read at the 14th Clinical Congress, Connecticut State Medical Society, New Haven, September 20-22, 1938.  
The study was made by L. H. Nahum and H. E. Hoff.

## Huge Syphilitic Aneurysm: Case Report\*

JOHN H. FOSTER, M.D.  
Waterbury, Conn.

Aneurysm of the aorta due to syphilis is not uncommon, but the following case seemed of unusual interest. The aneurysm reached a larger size than any of the hospital staff could recall having seen and a search of textbooks and of the recent current literature revealed no similar case.

Mrs. Jane S, 59 year old widow was first admitted to the ward service of the Waterbury Hospital February 3, 1934, complaining of cough and dyspnea of five months duration. The symptoms were brought on by exertion and had been getting worse. The cough was non-productive. She complained of pain in the right shoulder and of indigestion and distress in the epigastrium. There were no important gastro-intestinal, renal or neuro-muscular symptoms. Menopause had occurred at fifty-two.

She had eight normal children, five of whom were living and well. There was one still-birth in the last pregnancy. She had had no serious illness and no operations.

Physical examination showed a fairly well developed elderly woman. The heart was moderately enlarged, the left border being in the mid-axillary line. The right border was about 3 cm. to the right of the median line in the third intercostal space. The heart sounds were regular and the rate was 114 per minute. There was a blowing systolic murmur over the precordium, transmitted to the left axilla and back. Blood pressure was 120/54. There were rales at the bases of both lungs. The liver edge was palpable, 4 cm. below the right costal margin. There was no ascites nor edema of the ankles. The pupils reacted sluggishly to light and the knee jerks were absent.

Blood: Wassermann was 4 plus, nonprotein nitrogen was 45 mgm. per cent, sugar was 142.9 mgm. per 100cc. The urine contained slight to heavy traces of albumin, but no sugar. X-ray of chest on March 5, 1934, showed the diaphragm smooth, the costo-phrenic angles clear, apices clear.

The heart shadow was large, especially the left ventricle. The measurements were: M.R. 4.6 cm., L.D. 17.4 cm., T.D. 11.8 cm. Cardiac chest ratio 16.8-26 cm. Supra cardiac dullness 10.2 cm. Diagnosis: (1) Left ventricular hypertrophy, (2) Aortic aneurysm.

She was discharged with relief of the symptoms of heart failure on March 5, 1934, with the diagnosis of (1) Luetic heart disease, (2) Congestive heart failure, (3) Aortic Aneurysm.

She was readmitted on November 24, 1934, with increasing weakness and cough. This time on physical examination there was a soft pulsating tumor in the 2nd right interspace to the right of the manubrium sterni. There was marked pulsation in the neck. The heart was recorded as markedly enlarged, with increased width of base, but no

measurements were made. Blood pressure was 125/50 in the right arm and 120/50 in the left arm. Heart sounds were distant and of poor quality. The liver was again about 1½ cm. below the right costal margin. There was no edema. Following a chill on the 5th day in the hospital, the temperature rose to 104.5 but there was no change in the heart or lungs. The urine showed albumin 4 plus and a moderate amount of pus. The fever subsided and she was discharged after two weeks.

X-ray examination of the chest showed some increase in the supra cardiac dullness (11.2 cm.), the other measurements remaining about the same.

She was under observation at the dispensary for more than a year as an ambulatory patient. She was readmitted January 2, 1936. The mass had been growing steadily in size and was causing quite severe pain in the neck and right shoulder and was affecting her speech and breathing.

On physical examination she was mentally clear and cooperative, not suffering and not apprehensive. There had been no loss of weight and little change except for the aneurysm.



Fig. 1. Aortic aneurysm (anterior view) about a month before rupture.

\*From the Medical Service of the Waterbury Hospital



This tumor mass (Fig. 1) now extended from the right shoulder joint to the left of the sternum and from the right submaxillary region to the 3rd costal interspace. It measured about 17 cm. in each diameter and was raised about 6-7 cm. in the center. It had an expansile pulsation, was tense but not tender, and there was no definite thrill. The skin over this area was discolored, dark red-brown in color and was tense and shining. The left border of the heart seemed to be in the posterior axillary line. The heart sounds were rapid (114) and regular. There were both systolic and diastolic murmurs over the whole precordium, transmitted to the back. Blood pressure (Rt.) 124/58 (Lt.) 114/64. The lungs were clear. The liver edge was palpable, otherwise the abdomen was negative. Knee jerks were absent.

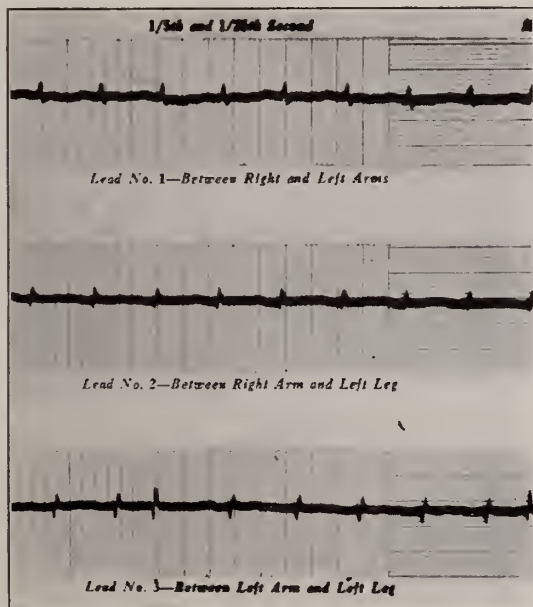


Fig. 2. Electrocardiogram showing tachycardia and nodal rhythm.

An electrocardiogram (Fig. 2) showed low voltage, tachycardia and nodal rhythm.

An X-ray (Fig. 3) showed increase of the mediastinal shadow but erosion of the bones was not demonstrated. The woman seemed oblivious to the seriousness of her condition. She was uncomfortable from the pressure in the neck and could not turn her head to the right nor could she bend her head forward on account of the mass under her chin. Small areas on the vertex of the aneurysm were soft, fluctuant, and darker in color, and from the time of her admission seemed in imminent danger of rupturing.

She was in bed most of the time but was up in a chair almost daily and ate well and slept well. She had morphine gr.  $\frac{1}{4}$  four to six times a day most of the time.

The tumor increased rapidly in size. One week after admission the dimensions had increased to 20 cm. transversely and 19 cm. vertically, while on January 31st the measurements were 22 x 21 x 9.5 cm. (Fig. 4).



Fig. 3. X-ray of chest Jan. 3, 1936, showing extension of mediastinal and cardiac shadows.



Fig. 4. Aortic aneurysm, Feb. 13, 1936, two weeks before death with beginning ulceration of surface.

On February 17th she seemed weaker and several superficial erosions appeared on the surface, with some oozing of serum. The tumor was now 25 x 26 cm. and extended up into the supra sternal region. Blood pressure (Rt) 115/80 and (Lt) 120/90.

The erosions became more ulcerative and on the morning of February 25 while she was sitting up and having her bed changed, she suddenly called to the nurse, "Oh look,

(Continued on Page 323)



# Neurological Manifestations in Pernicious Anemia

## A Report of Five Cases

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Attending Physician, Grace Hospital

SAMUEL SPINNER, M.D.

Resident Physician, Grace Hospital, New Haven, Conn.

Before the advent of liver therapy, pernicious anemia belonged in the group of uniformly and usually rapidly fatal diseases. No treatment had any chance of permanent control. The first transfusion of blood usually resulted in temporary and spectacular improvement for a period of months, rarely of years. The second transfusion resulted in a less spectacular and less prolonged remission. Shortly after the third or fourth transfusion no more benefit occurred and the patient made an exit "ad patres".

In no other disease, since the value of insulin in diabetes was demonstrated, has so much advance been made as in pernicious anemia treated by liver extract.

For years now, various symptoms and objective pathological findings have been relieved by treatment with the intrinsic and extrinsic factors of Castle. Improvement in one group of symptoms and signs has lagged far behind the others, i.e., the neurological group. It has long been possible to improve the red blood count, the symptoms of fatigue, and so forth, but it is still with regret that we see many individuals in whom central nervous system lesions do not improve or even progress in spite of liver therapy which had previously seemed adequate.

The excuse for this report of five cases\* lies in the fact that members of the profession are still unconvinced that adequate therapy will accomplish remarkable improvement and that there is still misunderstanding as to what represents adequate therapy.

\*Three from private practice by Dr. T. S. Evans.

Two observed in Grace Hospital service.

At present the use of the word "unit" is inordinately popular and covers a multitude of inexact details. There is still a rule of dosage taught by a revered member of the faculty at the "College of Physicians and Surgeons" (Dr.

Charles Lieb). "Use enough of the drug to accomplish the desired result unless evidence of toxic absorption intervenes." This is the only acceptable rule and like individual dosage with insulin must be suited to the case at hand. That one person maintains some power to create insulin, whereas another retains none is an accepted fact. We believe it to be true also that some individuals retain some active intrinsic substance though perhaps not enough to carry on full manufacture of red blood cells. It therefore seems to us necessary to suit the dose to the individual and to judge effectiveness of the dose by the results obtained.

### CASE 1

Case Report, M.M. A Woman of Italian descent. 51 years of age.

Personal History: Until one year ago the woman was never ill in her life. At that time she began to have difficulty in walking, finding that she staggered and that her legs were very weak. About six months ago, April 1938, she became constipated and her appetite became very poor. This latter symptom together with weakness increased gradually in severity, until one month ago she found it impossible to get out of bed and also impossible to eat. She has had no cardio respiratory symptoms. She has had no urinary symptoms. Her menses had been regular until six months ago when she became irregular. She has lost many pounds, probably twenty-five. She has slept well. She has been cross and irritable.

Family History: Her husband is well. Her seven children are well. No deaths have occurred in the family. There is no history of pernicious anemia in the family. She has had a good many types of treatment, the last being injections of theelin with the idea of improving the menopausal symptoms. None of her treatment has been effective.

Physical Examination — September 12, 1938: Temperature 99.2. Pulse 72. Blood pressure 150/90. Weight 120. She is a very sallow Italian woman of fifty-five without cyanosis, dyspnea, or edema while lying in bed, but with marked dyspnea on exertion, however slight. The eyes and eye grounds are normal. The tongue is smooth. The nose, throat and ears are normal. There are a few bad teeth with snags and infected gums. The

neck, breasts, heart and lungs are normal. The abdomen, extremities and external genitalia are normal. The cervix is rough and bleeds at the slightest touch. Visualization shows cystic cervicitis. The uterus is small. There is no pain on motion of the cervix. The reflexes are all exaggerated. With help she was made to stand at the bedside, but with her eyes open and a supporting hand the Romberg was strongly positive. The gait could not be determined because of the patient's inability to walk. The urine is negative. The Wasserman is negative. The blood count reveals a hemoglobin of 60 per cent (Talquist), an erythrocyte count of 1,500,000, and a leukocyte count of 4,000. The blood smear shows very marked anisocytosis, poikilocytosis and achromia. The red blood cells are very large.

The patient was given  $\frac{1}{2}$  cc. of reticulogen for ten doses, daily.

She was seen again September 22, 1938. When asked to walk the patient finds that she can proceed alone, although on a very wide base. The Romberg is positive, the vibratory sense absent in both legs. The blood count reveals the following: erythrocyte count 2,800,000; leukocyte count 7,000, polys 78 per cent, small mononuc leaks 18 per cent, monocytes 4 per cent. The cells are still very large. The reticulocyte response is 16 per cent. Free HCL is not found in the gastric contents. The recitologen was continued at  $\frac{1}{2}$  cc. daily.

September 29, 1938. The patient is able to come to the office and to walk from the waiting room to the office without help. She feels better, has a good appetite, suffers no fatigue, and has regular bowel movements.

Physical Examination: Pulse 92. Blood pressure 120/80. Weight 127. Her general appearance is better. The tongue shows some roughness. The papillae are returning. She herself has noticed the roughness of her tongue. The reflexes are still exaggerated. The gait is considerably less wide. She is able to stand with her eyes open and without help. The Romberg test is positive with the eyes closed. The blood count reveals a hemoglobin of 80 per cent, an erythrocyte count of 4,000,000, and a leukocyte count of 7,000. The blood smear reveals the following percentage: polys 68, small mononuclears 18, monocytes 11. The red blood cells are still macrocytic, but not as large as previously, and show slight achromia. Reticulogen was continued at  $\frac{1}{2}$  cc. daily.

October 13, 1938. The patient feels well, but has a backache in the sacral region.

Physical Examination: Weight 130. Blood pressure 150/90. Pulse 72. The tongue is of normal appearance. The Romberg test is positive. The patient is able to walk downstairs without aid. She receives  $\frac{1}{2}$  cc. of reticulogen daily. The blood count reveals a hemoglobin of 84 per cent, an erythrocyte count of 4,100,000, and a leukocyte count of 6,400. The blood smear shows the following percentages: polys 68, small mononuclears 18, monocytes 4 and eosinophiles 2.

October 27, 1938. The patient "feels 100 per cent and eats all the time". She still has a little backache. She receives 1 cc. of reticulogen twice a week.

Physical Examination: Weight 134. Blood pressure 150/90. Pulse 72. The tongue is normal. The reflexes are still exaggerated. The gait is good. The patient is able to walk with eyes closed, the Romberg still positive, but not marked. The blood count reveals a hemoglobin

of 87 per cent, an erythrocyte count of 4,500,000 and a leukocyte count of 6,500. The blood smear shows the following percentages: polys 74, small mononuclears 19 and monocytes 7.

The patient continues to receive 2 cc. of reticulogen weekly.

In light of the history, physical findings, and laboratory examinations, I think it is evident that this woman has pernicious anemia. I also believe her response to liver therapy further supports this diagnosis.

There are several points of interest to me in this case, namely:

1. The woman has been completely incapacitated due to her central nervous system symptoms. Her response to liver in this respect is better than could have been expected. She has not made a complete recovery to normal since her vibratory sense is absent, her reflexes are still exaggerated and she has no free hydrochloric acid in her stomach; but she is able to eat, has gained fourteen pounds and is able to walk and do a great percentage of her housework. This return to function has been extremely rapid. The response of both the red blood cells and reticulocytes has been prompt and of large proportions.

2. The profession has been reluctant to accept concentrated liver extracts because of the feeling that their antineuritic properties are insufficient to protect the patient against central nervous system degeneration. This woman has received nothing but reticulogen, the most concentrated of all liver products and has made great improvement.

3. Rhoades recently stated at the New York Academy of Medicine that he has been able to produce anemia by the use of progynon, an endogenous aromatic hydrocarbon. The part which may have been played by the injection of theelin certainly is not clear cut, but it is worthy of some notice. The suggestion is made that we be cautious in the use of this type of glandular therapy

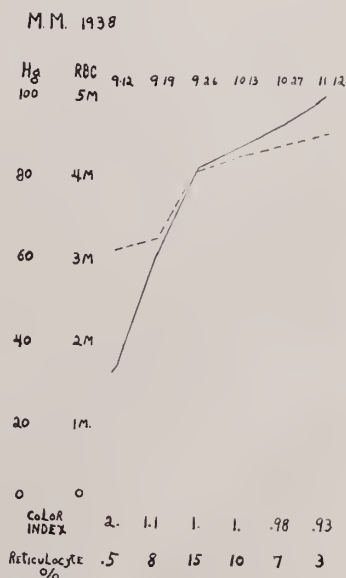


Fig. 1

and follow cases with blood counts when using this treatment.

In all graphs the full line represents Red Blood Cells and the broken line Hemoglobin.

### CASE 2

Case Report, A.L. 53 years old. Swedish. Male.

The patient was admitted to Grace Hospital, New Haven, Connecticut, on April 26, 1937 and discharged June 7, 1937.

He complained of weakness, shortness of breath, dizziness and tingling of the extremities for one and a half years, during which time there were remissions of symptoms. His only gastrial intestinal symptoms have been eructations of gas. He has been treated by many physicians with many different medications but without benefit.

Physical Examination: The tongue is smooth. The vibratory sense is absent. The reflexes are normal. The spleen is palpable. The blood count as reported April 26, 1937, shows the following: hemoglobin 30 per cent, erythrocyte count 1,050,000, leukocyte count 5,200, polys 39 per cent, small mononuclears 52 per cent, monocytes 5 per cent, reticulocytes 0.2 per cent, and platelets 50,000. The blood count as reported April 27, 1937 shows the following: hemoglobin 40 per cent, erythrocyte count 900,000, leukocyte count 3,800, polys 36 per cent, small mononuclears 42 per cent, monocytes 14 per cent, reticulocytes 0.2 per cent, and platelets 50,000. The urine contained some albumin at first but later it was entirely negative. There is no free HCL in the stomach contents. The Wasserman is negative. The blood sugar is 90 milligrams. The non-protein nitrogen is 47 milligrams. Roentgenogram of the chest shows the costo-vertebral angle obliterated on the right side.

April 27, 1937 the patient received a transfusion of 500 cubic centimeters of citrated blood. Beginning April 28, 1937 he received one ampule of liver extract daily. Except for an abscess of the buttocks, his recovery was rapid and complete. He was advised to come to clinic once a week for liver extract injections. He was not seen until June 1, 1938 when he stated he had been working every day until one month previously at which time he developed the same symptoms as he had had before. During this year he had received no treatment.

He was readmitted to Grace Hospital June 1, 1938. For some time before admission to the hospital he was very weak, due to the constant increase in the severity of the symptoms. Three days before admission he was unable to walk at all.

Physical examination again gave evidence of a smooth, sore tongue, loss of vibratory sense and entire absence of reflexes. The patient could not walk or even stand. He again had no free HCL in the stomach contents.

The blood count taken on day of entrance to hospital, showed a hemoglobin of 20 per cent and an erythrocyte count of 600,000. He was given two transfusions the first three days after admission, and five cc. of Lilly's concentrated liver extract daily. At the end of twelve days of this treatment he was able to walk and his blood count then showed a hemoglobin of 60 per cent and erythrocyte count of 3,290,000. He continued an uphill course with marked increase in the hemoglobin, erythrocyte and reticu-

loxyte response until June 29, 1938 when he was able to leave the hospital.

Although he is slightly irregular in his attendance at the clinic he has stated on a few occasions there that he has been able to work, has no difficulty on locomotion, and physical examinations have corroborated these statements.

NOTE: Like Case 1 (M.M.) this man responded promptly to liver extract. The product used on the first admission to the hospital was Upjohn's Liver Extract. That used in the second admission was Lilly's concentrated Intramuscular Liver Extract, dosage five cubic centimeters. His neurological signs disappeared rapidly and almost completely.

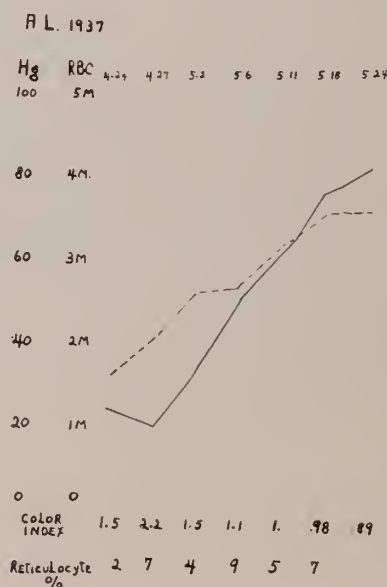


Fig. 2A



Fig. 2b



## CASE 3

Case Report, F.D. Female. 65 year old store worker.

The patient entered Grace Hospital October 13, 1938, with complaint of tingling of extremities and numbness for five years.

Until five years ago she felt perfectly well. She then developed progressive weakness, fatigue, tingling of extremities and numbness. Many physicians were consulted and the patient was given liver injections. All of her symptoms were relieved as the result of this treatment. Unfortunately, the product used at this time is unknown.

Two years ago the patient stopped all treatment and gradually all of the previous symptoms returned. She began to lose her appetite. Shortly before entry to the hospital she became nauseated and vomited all her food. Her weakness progressed to the point of complete inability to walk. The patient has gained fifteen pounds in the past five years.

Physical Examination: The patient is an obese, elderly, female with lemon-yellow skin and marked pallor of the mucous membranes. There is definite smoothness of the tongue. The liver and spleen are not palpable. The extremities are very weak. The vibratory sense is absent from the knees down. The ankle and knee jerks are also absent. The blood pressure is 90/40. There is no free hydrochloric acid in the stomach contents.

On admission to the hospital the patient was given a transfusion of five hundred cubic centimeters of citrated blood. The first three days in the hospital she received four cubic centimeters, daily injections of Upjohn's liver extract. Two cubic centimeter injections were then administered daily until her discharge. The erythrocyte count rose rapidly from 1,200,000 to 4,300,000 under liver therapy. The reticulocyte response was normal. After ten days the central nervous system symptoms showed slight improvement. After thirty days the patient was able to walk without aid.

The patient was discharged from the hospital November 19, 1938. She felt "completely well" and was able to

walk again. The knees and ankle jerks returned. The vibratory sense had partially returned but was still slightly impaired. The numbness and tingling of extremities had entirely disappeared. Like cases 1 and 2 this woman showed very great progress under liver extract therapy.

## CASE IV

Case Report, M.S.M. 52 year old Polish woman.

April 26, 1938. One year ago the patient had an acute illness and as a result has been paralyzed on her right side. Two years ago she complained of feeling weak and drowsy, with heaviness of the feet and tingling in her toes and fingers. She experienced difficulty in walking and suffered from sore tongue and loss of appetite. There was no change in her bowel habits. There was no nausea. She went to the hospital and was transfused because she had anemia. Her condition then became worse and she was unable to walk. At the hospital she received liver injections every day for a month. Since that time she has received every week two injections of Lilly's concentrated liver extract, each 2 cc. Her blood count was said to be normal. HCL was not found in the stomach. Her urinary symptoms were negative. Her cardio-respiratory symptoms were negative. Her menstrual periods were irregular, probably due to menopause. The patient had lost weight, felt tired, but slept well. She had influenza in 1918 and has been well since then.

Family History: Her husband is well. Her three children are well. There is no history of pernicious anemia in the family.

Physical Examination: Weight 133. Blood pressure 160/105. Pulse 80. Her general appearance is good. The eyes, eye grounds, nose and throat are normal. She has several bad teeth. The tongue is not smooth. The breasts, lungs, abdomen, extremities and external genitalia are all normal. She has cyanosis of the lips. The vaginal examination reveals cystic cervicitis. Hemoglobin 96. Erythrocyte count 4,800,000. Leukocyte count 5,000. Polymorphonuclear leukocytes 58%. Small mononuclears 39%. Monocytes 3%. The woman is unable to walk without assistance on both sides. Her gait is typically spastic. Her reflexes are exaggerated and a slight Romberg sign is present. Her vibratory sense is absent. The Wasserman is negative. The stomach contents are negative for HCL.

The history of this case suggests two possibilities. First, the two year history of weakness, tingling of the extremities and anemia is suggestive of anemia of two years duration. Secondly, the accident one year ago is suggestive of cerebral hemorrhage, but, at present the status of the patient would suggest that this has cleared up and the present picture is due to central nervous system disease, dependent on pernicious anemia. The absence of HCL also points strongly in this direction.

The administration of liver extract would account for the present blood count and the absence of smooth tongue. It was decided to treat the patient intensively with liver extract and so for one month the patient received 5 cc. of Lilly's concentrated extract daily. At the end of that time the blood count revealed a hemoglobin of 100 per cent and an erythrocount of 5,000,000.

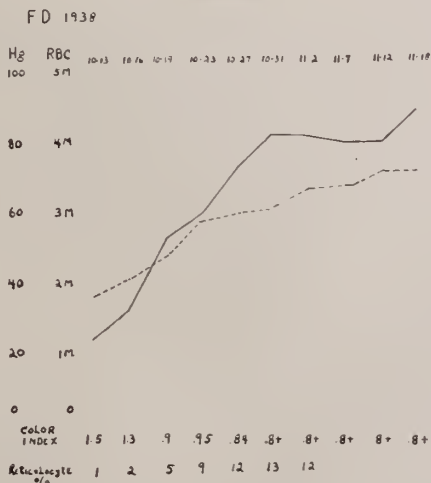


Fig. 3

There was nothing characteristic about the smear. The patient felt better, was able to do some of her house work, and could walk unassisted, but she still had a spastic gait. She weighed 140 pounds.

During the next two months the patient's improvement was so great that she could get out into the yard to do some gardening and could also perform a greater part of her household duties.

The blood count was practically stationary at over five million. The reflexes were exaggerated. The vibratory sense was absent. The stomach contents were negative for HCL. The gait still was on a broad base and the Romberg positive.

This case illustrates two very interesting things.

1. Although the patient received adequate treatment with liver extract over a period of a year so that the blood count was normal, her central nervous system symptoms did not improve. When she was given larger and more frequent doses of liver extract a considerable, but far from complete, improvement occurred.

2. Although the patient's objective improvement is partial, her subjective improvement is almost complete, since she feels well and is able to do a very large portion of her duties, despite her staggering gait.

Unfortunately, the patient has refused to come in during the last three months, but indirect reports from her family indicate that she has maintained her previous gain, although it does not appear that she has made any further progress.

She is now receiving one 5 cc. injection of Lilly's concentrated Liver Extract weekly.

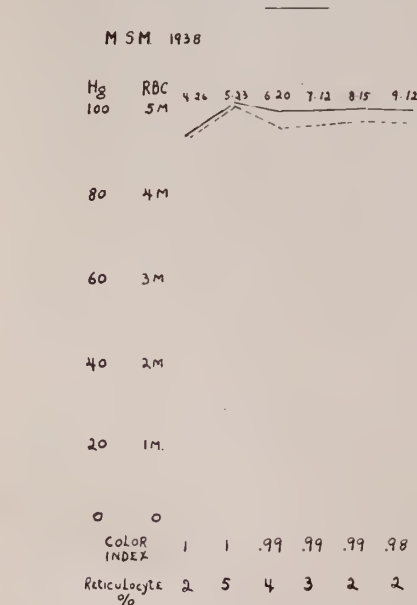


Fig. 4

CASE 5

Case Report, M.McK. A white woman of Dutch extraction, 60 years old.

September 23, 1938 Three years ago the patient noticed general weakness, tingling of fingers and toes, sore

tongue, loss of appetite, diarrhea and heaviness of the feet. She received treatment from an osteopath and at first thought she was getting along very well, but after one year she sought the advice of one physician after another without receiving benefit. One physician started her on parenteral liver extract and later changed to a mouth preparation, extralin. Under his care she did well, but soon tired of the treatment and one year ago lapsed back to her former condition. She made up her mind that her condition was hopeless, that no treatment would help her, and now she is practically disabled because of her inability to walk. All of her previous symptoms in more severe form have returned. Now she is so weak that she is unable to bathe and get to the bathroom. She must be half carried to the commode.

Physical Examination: She is a pale, lemon yellow colored, well nourished and well developed woman. There is no cyanosis. The eyes, ears, nose, and throat are normal. The tongue is smooth. The neck, breasts, heart, lungs, and abdomen are normal. The extremities are normal. The external genitali are normal. Both the deep and superficial reflexes are absent, except for slight response in the two biceps. The patient is unable to stand or walk. She has lost fifty pounds. The temperature and pulse are normal. The blood pressure is 180/100.

The blood count reveals a hemoglobin of 70 per cent an erythrocyte count of 3,300,000 and a leukocyte count of 7,600. The blood smear shows 76 per cent polymorphonuclears, 16 per cent small mononuclears, 8 per cent monocytes, together with marked achromia, poikilocytosis, anisocytosis, a few normoblasts and macrocytic cells.

There is no free hydrochloric acid in the stomach contents. The patient was given 1 cubic centimeter reticulogen daily for two weeks. At the end of one week she felt much better and had gained strength. Her appetite was returning.

September 30, 1938. Her general appearance is improved, and she is able to get out of bed to go to the bathroom, although she staggers in doing so. The tongue is unchanged. The temperature is normal. The pulse is 72. The blood count reveals a hemoglobin of 60 per cent, an erythrocyte count of 3,900,000 and a leukocyte count of 8,600. The blood smear reveals a reticulocyte response of 12 per cent together with marked achromia, anisocytosis and poikilocytosis. The patient now received 1/2 cubic centimeter of reticulogen daily for two weeks.

The patient feels subjectively improved. She is doing her own cooking, feels like reading, walking and seeing her old friends for the first time in a year. Her gait is still bad, the reflexes still absent, but her mental state much improved. She even looks forward to getting outdoors.

October 7, 1938. During the past five weeks the patient has received 1 cubic centimeter of reticulogen twice a week. She has improved more subjectively and gained in strength. Her gait is staggering, the vibratory sense has not yet returned, but she is able to go outdoors, do some gardening, see her friends, and do a limited amount of housework. Her tongue has begun to show roughness.

The blood count reveals a hemoglobin of 85 per cent and an erythrocyte count of 4,300,000. While some of the



cells are still macrocytic, the poikilocytosis and anisocytosis are greatly improved, until at the present time they are practically absent.

This case is of interest for several reasons.

1. The patient had a profound mental depression and had decided that nothing was worth while.
2. Her erythrocytes and subjective symptoms improved greatly as the result of liver therapy.
3. Her mental outlook improved also. This was due in part, I believe, to her improvement in physical state, but also due to the encouragement she received and to the recognition of the fact that she is able to do a great many of the things she wishes.

the pleasure also of personal discussions with Dr. Paul Reznikoff and Dr. Claude Forkner of New York City.

Many of these more recent contributions where many different observers have pointed out various aspects of combined syndrome disease in pernicious anemia have not yet appeared in literature.

These five cases illustrate some of the points which were stressed in various discussions.

1. The importance of early diagnosis and treatment.
2. The use of large amounts of liver extract.
3. The fact that short duration of symptoms always gives hope of good prognosis.

One additional point of interest to which Dr. W. P. Murphy\* and Isabel Howard have recently called attention in print and which has been discussed by Dr. Paul Reznikoff is also illustrated, i.e., that concentrated forms of liver extract seem to have caused almost complete remission of symptoms in spite of the fact that many hematologists still feel that the unconcentrated forms contain some factor not exhibited in the concentrated forms.

Concentrated liver extract, reticulogen, was used in two cases. Case 1, where the central nervous system lesions were of relatively short duration, made spectacular recovery and sustained improvement. Case 5, where duration of central nervous system lesions was a long one, made considerable subjective improvement and some objective improvement

In Case 3 we had good results from the use of Upjohn's liver extract in frequent two cubic centimeter doses.

Case 2 received Upjohn's liver extract on his first admission and very good results were obtained. On his second admission he received Lilly's concentrated liver extract in five cubic centimeter doses and also made very great progress.

Case IV, where the symptoms had been of long standing and small doses of liver extract had been used, made much more improvement in central nervous system lesions after receiving larger doses of liver extract than she had made previously on small doses.

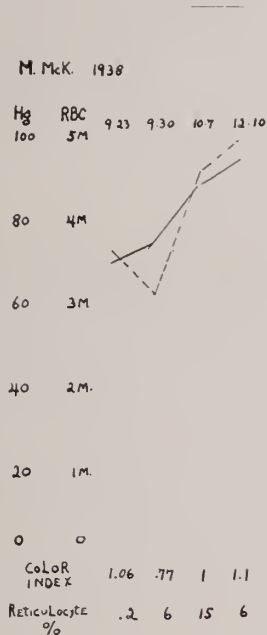


Fig. 5

Summary

Descriptions of improvement in central nervous system lesions of pernicious anemia under treatment with liver are by no means new. At the meeting of the American College of Physicians in April 1938 and of the Graduate Fortnightly of the New York Academy of Medicine in November 1938 many reports of good results were given. Among those referring to the various important factors were Dr. George Minot of Boston, Dr. H. A. Abel of New York City, Dr. Joseph Connery of New York City, Dr. Cyrus C. Sturgess and Dr. Rapheal Isaacs of Ann Arbor, Dr. Randolph West of New York City, Dr. Maurice Strauss of Boston, Dr. Russell Hayden of Cleveland, and the various workers in the field at the different medical centers. I have had

\*J.A.M.A. January 14, 1939; Volume 112; Number 2; Page 106.



## Life Insurance—A Design for Living

EDWIN H. SNOW,\*  
Hartford, Conn.

"Dr. H. J. Jones, 40, died yesterday."

Thus read the first line of an obituary notice in a midwestern daily paper on the morning of May 12, 1928.

Dr. Jones had been a kind man, a thoughtful husband and father, providing well for his family. He was purchasing a home in one of the better suburbs so that the children might have the advantage of the associations in the locality. He belonged to the Country Club around which most of the social activities of the community revolved. The family spent their summers at their modest but comfortable cottage on one of the Wisconsin lakes; the doctor spending his week-ends with them when his practice allowed him to get away from home.

He had worked hard in order to give these advantages to Mrs. Jones and the children, and he had sacrificed to meet the premiums on his life insurance that one day might be called upon to take care of his family.

Unfortunately, the entire proceeds of his life insurance were left in a cash sum to his family.

Mrs. Jones invested the money in "A-1" securities, and for the next year everything went well with the little family; in fact the value of the securities increased during the first year.

By the fall of 1930, however, Mrs. Jones was forced to sell their home in the suburb, and the family moved to an apartment in the city. The summer cottage on Crescent Lake was put in the hands of a real estate agent in the hope that a buyer might be found.

In the Spring of 1931, Mrs. Jones secured a position as office assistant to Dr. James, and the older of the children, a son, left high school to take a job as file clerk in the drafting department of a large railroad.

Today Mrs. Jones is being supported by her son and daughter, the son still employed by the same railroad at \$25 a month more than he was earning in 1931, the daughter clerking in a department store.

Through an appropriate selection of the methods of settlement which were contained in Dr. Jones' policies, his life insurance could have paid off the mortgage on the house; could have provided Mrs. Jones with an income sufficient to take care of her reasonably well for the rest of her life; and would have provided the additional income needed to send both of the children through the State University.

Properly planned, Dr. Jones' life insurance could have been a monument to his name rather than a series of heartaches and disappointments to his family.

Included in practically every life insurance policy are three methods of settlement, usually referred to in the policies as Settlement Options, or Modes of Settlement. While the order of their inclusion in the policy varies somewhat with companies, the three methods of settlement are these:

First, the company agrees to hold the proceeds of the policy and pay a guaranteed and stipulated rate of interest to the beneficiary or payee either monthly, quarterly, semi-annually, or annually. Thus the payee has for all intents and purposes a bond with a guaranteed face value and a guaranteed rate of interest.

The second option provides that the company will pay the proceeds of the policy over a definite period of years, usually from one to thirty, using both the principal and the interest.

Under the third option, the policy provides that the proceeds can be paid as an annuity for the lifetime of the payee with a certain number of payments guaranteed to be paid whether the payee lives or not.

Through a study of your particular problems, and the application of the foregoing Settlement Options in your present policies, the trained life insurance man is able to mold your life insurance into a plan — a life insurance *will*, if you please — to accomplish the things you wish accomplished for your family should your death be premature.

\*Field Supervisor—Aetna Life Insurance Company

But this, the problem of premature death is only one of the financial problems confronting the modern physician.

Of equal importance is the problem of providing for old age, and guaranteeing beyond the shadow of a doubt that he will not be dependent upon anyone in the later years of his life when it becomes necessary for him to lay aside his "bag."

Fortunately, in all life insurance policies (term insurance excepted) are guaranteed cash values which increase year by year as the premiums are paid. Most life insurance policies provide that the same Settlement Options which are used to provide income to a beneficiary upon the death of the insured can be applied to the cash values of the contracts. Hence an insured can request the company to pay him an annuity from the cash values of his policies, utilizing the third option in the contract.

A minimum of five basic points should be considered in the formation of an adequate life insurance program for a man with growing children

#### 1. Cash For Final Expenses.

This includes Last Illness Expense, Funeral Expenses, Outstanding Bills, Unpaid Taxes, Mortgages, and the like—any money that must be paid in cash immediately or soon after death.

#### \*2. Monthly Income Until the Children Are Self supporting.

Expenses are greatest while the children are growing up and are dependent upon their parents. Therefore, it is necessary to provide a maximum income during this period to take care of the extra expenses.

#### 3. Monthly Income to Wife For Life.

After the children are self-supporting Mrs. Physician, of course, must have an income but it can be considerably less than that afforded during the period in which the children are growing up.

#### \*4. Educational Funds For Children.

To arrange life insurance in such a manner as to provide for this important item is the only sure method of guaranteeing that the money will be on hand when it is needed.

#### 5. Retirement Income For Self.

Expenses are less at this time of life. The children are grown and self-supporting. An income sufficient to support yourself and wife should be provided.

In determining amounts needed under the first four items, it is well to consider that your policies have become a claim, and assume for the moment that you are the Executor of your own estate. What are the minimum amounts of money that will be needed by your family under these first four items?

Under the last item (Retirement Income For Self), what is the minimum income necessary to take care of yourself and wife with a reasonable degree of comfort at age 65 or whatever age you desire to retire?

Having determined your minimum requirements, your life underwriter is in a position to formulate your program, and you will have made certain that your family will be taken care of in event of your premature death; made certain that the sunset years of your life will be spent in security, free from the horrors of dependency or want. Furthermore, the increasing cash values of your policies, as the years go by, will provide you with a splendid emergency fund for unforeseen contingencies. Your life insurance program has become the keystone of your financial house.

Truly, your life insurance has become a design for living.

\*If there are no dependent children in the family, you will naturally exclude these items. On the other hand, if you have a dependent relative you may wish to include him or her in your program.

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# Association of Connecticut Tumor Clinics

## A Symposium on Cancer of the Prostate

Presented at the Twelfth Meeting of the Association held at New Haven Hospital, March 10, 1939

### I. CARCINOMA OF THE PROSTATE IN WATERBURY

C. H. Neuswanger, M.D.

A review of the cases of carcinoma of the prostate was made in the two Waterbury Hospitals for a period covering the past ten years. In this series of cases only those which were proven to be carcinoma by operation, biopsy, and post-mortem examinations are included. A total of seventy-five cases was found as follows:

1938-39	20 cases
1937	11 cases
1936	10 cases
1935	10 cases
1934	13 cases
1933 and previous	11 cases

The following disposition was made of these seventy-five cases:

Cystotomy	20 cases
Perineal prostatectomy	15 cases
Transurethral prostatectomy	13 cases
Suprapubic prostatectomy	4 cases
No operation	23 cases

The age groups were as follows:

40-49	3 cases
50-59	12 cases
60-69	32 cases
70-79	15 cases
80-89	12 cases
90-99	1 case

The following table shows the length of time which the patients lived after the diagnosis was made:

1 year	13 cases
2 years	30 cases
3 years	18 cases
4 years	10 cases
5 years	2 cases
6 years	2 cases

Of the total of seventy-five cases, fifteen are still living and the length of life since a diagnosis was made is as follows:

1 year	2 cases
2 years	6 cases
3 years	3 cases
4 years	1 case
5 years	2 cases
6 years	1 case

Of the sixty cases that died, fifty-two of these deaths were directly attributable to the carcinoma. Eight of these sixty cases died of the following causes:

Operative deaths	2 cases
Heart disease	2 cases
Pneumonia	2 cases
Accident	1 case
Suicide	1 case

One of the two operative deaths was due to a gas bacillus infection in the wound following a perineal operation. The suicide was a case in which the patient's son told his father that he had cancer about two years after the diagnosis was made and the patient promptly shot himself.

A study of the nationalities of these various patients was made and the following information was found:

Old American stock	26 cases
Irish	24 cases
German	9 cases
French	5 cases
Swedish	3 cases
Poles	3 cases
Italian	2 cases
Lithuanian	2 cases
Hebrew	1 case

Although a similar study of the nationalities of cases with benign enlargement of the prostate was not made, it is very apparent that certain



nationalities are more prone to carcinoma of the prostate. For instance, benign enlargement of the gland is very common among Hebrews; only one case of carcinoma was encountered in this entire series. In contrast to this there is a very high incidence of carcinoma among patients of Irish extraction.

During the past ten years a total of two hundred thirty-one (231) cases have been operated upon for benign enlargement of the prostate as compared with fifty-two (52) cases of carcinoma. This is roughly twenty-two and a half per cent.

From a study of the above tables it would appear that many cases are being diagnosed earlier than in previous years and that in a small percentage of cases there is still hope for a cure.

## II. CANCER OF THE PROSTATE

Allen M. Margold, M.D.  
Norwalk General Hospital

We regret that we have not prepared a formal paper on this subject. We have had a series of about thirty cases of carcinoma of the prostate at the Norwalk General Hospital during the past five years. Each case presented an individual problem and, in general, our therapy followed the routine for this disease. Where there was residual urine and obstruction at the vesical neck, transurethral resection was resorted to as a palliative procedure to relieve the symptoms. Many of our cases were also given radon seeds, either perineally or suprapubically.

Because of the insidiousness in the progress of this disease, because of the deceptiveness in its clinical manifestations and the seriousness of its consequences, carcinoma of the prostate is a challenge to all in its diagnosis and treatment.

The common conception that carcinoma of the prostate must be large, stony hard, and markedly irregular, is erroneous, and because of this fact patients are sent to the urologist so late in the course of the disease that any possibility of cure is precluded. Most of the cases we have had at the Norwalk General Hospital have been well advanced malignancies. We have not seen any case suitable for radical operation. It is my opinion that even the small, firm fixed prostate that presents nodules and is diagnosed as a cancer presents a disease that has already disseminated. John Caulk stated that he had never

seen a case of carcinoma of the prostate that had been cured. The only cases of carcinoma of the prostate that we have seen which we believed cured are those in which carcinoma has been an incidental finding. We have three cases where carcinomatous islets were found in prostates that were removed for benign hypertrophy. These cases are now alive and well, symptom free, nine, six and three years post-operatively, respectively. Our challenge is for early diagnosis and improvement in therapy. Cure must be sought! We believe it to be our duty to advise the medical profession to do more rectal examinations and to call attention again to Young's seven points of value in differentiation:

1. Extensive induration with adhesions and fixation of the prostate, especially if involving the seminal vesicals, should always cause the examiner to suspect carcinoma, even if the induration is not stony.
2. Nodules markedly firmer than the surrounding prostate.
3. Thickening of the membranous urethra, fixation and obscuring of its outline.
4. Similar changes in intravesical notch.
5. Thickening and induration of the lymphatics and lymph nodes about the tip of the seminal vesicals.
6. Examination with finger in rectum and sound or cystoscope in the urethra.
7. Presence of benign hypertrophy in no way excludes carcinoma.

We have not, in this paper, discussed any subjective symptoms, as we do not feel that they are at all unique to this disease.

It must always be kept in mind that carcinoma of the prostate is a prevalent disease, that its incidence is on the increase, and that the early case presents the only one with possibility of cure. Always be suspicious of those regions in any prostate that show areas of thickening, or any variation from the normal rubbery feel.

## III. REPORT OF MALIGNANCIES OF THE PROSTATE AT THE WINDHAM COMMUNITY MEMORIAL HOSPITAL, 1928-1938

Edward J. Ottenheimer, M.D.

In the past ten years there were admitted to the Windham Community Memorial Hospital in

Willimantic 64 tumors of the prostate gland. Of these, 52 proved to be benign and 12 malignant. In other words, approximately 18% of all prostatic tumors at our clinic were found to be malignant.

In the 12 malignant cases, there were 2 in the age group between 50 and 60, 6 in the age group between 70 and 80, and 4 in the age group between 80 and 85. The average age was 75.

The diagnosis was verified by pathological report in all but three instances, and these three clinically were strongly probable malignancies.

The first symptom noticed by the patient was frequency in 5 cases, difficulty in voiding in 4 cases, incontinence in 2 cases, and hematuria in only 1 case. We have also reviewed the histories on all cases of benign adenomata admitted to the Hospital and find that essentially the same initial symptoms occur as in the malignant cases. We do not feel, therefore, that there is any one symptom of prostatic enlargement which gives any clue as to the nature of the pathological process. In all the malignant cases, however, on rectal examination the examiner noticed the definitely hard consistency of the gland which made him suspect malignancy pre-operatively. We feel, therefore, that rectal examination should be very carefully done on all patients presenting early symptoms of prostatic enlargement.

The interval between the first symptom noticed by the patient and the time of admission to the hospital for our prostatic malignancies averaged about 18 months. This compares somewhat unfavorably with an average of slightly over 12 months for all malignancies in our clinic during the same 10-year period. While 18 months seems an appalling delay, we found on reviewing the benign adenomata with almost identical symptomatology that the time between the first symptom and admission to the hospital averaged almost 4 years.

Of the 12 malignant cases, 1 was so far advanced that no treatment at all was deemed advisable. Of the remaining 11, 4 had only palliative supra-pubic cystotomy and 7 had prostatectomy. Of these, 6 were simple and therefore palliative prostatectomies, and 1 was a radical prostatectomy performed by Dr. Bidgood. Of the 11 operative procedures, there was

only one death post-operatively and that occurred after a simple prostatectomy.

Of the 11 cases which were treated, the following results were obtained:

Of the 4 cases treated by palliative cystotomy, none died post-operatively; 2 died the first year; 1 died the second year; 1 is living at the end of two years.

Of the 6 cases treated by palliative prostatectomy, 1 died post-operatively; 1 lived 6 years; 2 lived 2 years; 1 lived 1 year; 1 is living at the end of 2 years.

The case treated by radical perineal prostatectomy is living and well at the end of 2 years.

It is our feeling in the Windham Clinic that the ideal to be attained in prostatic malignancy is early diagnosis, plus radical perineal prostatectomy. If, as our figures indicate, there is a delay of 4 years between the first symptom and hospital admission in cases of benign tumors of the prostate and 1½ years in cases of malignant tumors of the prostate, with practically identical incipient symptomatology, we must assume that we are failing to educate middle-aged and elderly men, and doctors of all ages, to the realization that frequency, difficulty in voiding and other early symptoms of prostatic enlargement are not the natural heritage of advancing years, but point to the beginning of either a benign or a malignant tumor of the prostate gland. We are failing to emphasize that 18 to 20% of all tumors of the prostate gland ultimately prove to be malignant and we are failing to teach students and doctors to do discriminating rectal examinations.

We believe in our clinic that radical perineal prostatectomy is a formidable procedure which should not be undertaken by general surgeons, but by urologists who have had extensive experience with prostatectomy through the perineal approach. While the procedure almost inevitably is followed by incontinence, this seems to us far less troublesome than colostomy following radical removal of the rectum. While it is true that these patients are as a rule old and necessarily poor risks, so that palliative treatment can be undertaken with more enthusiasm than with malignancies in a younger group, it is our feeling that more patients should be coming to the urologist when radical perineal prostatectomy would be justified.



#### IV. CARCINOMA OF THE PROSTATE HARTFORD HOSPITAL

Charles Y. Bidgood, M.D.

The number of cases listed in the Tumor Clinic at the Hartford Hospital from 1930 to 1938 is 145. This does not represent all of the cases in the Hartford Hospital between 1930 and 1933, because up until that time only the service cases were listed by the Tumor Clinic. Since 1933 all cases have been listed. Of these cases, the diagnosis was made by X-ray in 24 instances; by autopsy, 9; 55, by pathological specimen; and 57, clinically.

The types of treatment given were as follows: 23 cases were treated by X-ray alone. Most of these were ones in which the condition was so far advanced that Roentgen therapy was used mainly to relieve pain; 6 cases were treated by a combination of X-ray and radium. Very little radium is now being used in treatment of prostatic cancer. 63 cases were operated upon. 18 of these were treated with the combination of operation and X-ray. 34 cases received no treatment at all, usually because the condition was so far advanced that no form of therapy seemed to offer any hope.

**Results.** From these 145 cases the 24 cases seen during 1938 are deducted because it is felt that the time has been so short that the results in these cases would not mean anything. Of the remaining 121, 66 died in the first year, 13 in the second, making 60 per cent death within 2 years. At the end of four years 85 per cent of the cases have died.

A word regarding morbidity statistics, particularly in carcinoma of the prostate. It is common knowledge that the individual who analyzes these cases usually gets more out of the analysis than any one else. After one has completed the survey, certain figures have been arrived at and certain impressions have been obtained. It is my belief that very frequently the impressions are likely to be as accurate as the figures. The present study is a case of point. According to the figures, 15 per cent of the patients with carcinomata of the prostate are alive at the end of four years. Excluding the results in radical prostatectomy, of which there are very few, the impression obtained is that this figure is probably too high.

Morbidity statistics, particularly in men past middle age, are notoriously inaccurate. The

reason for this is that after they leave the hospital the follow-up is very questionable unless it is possible to have the patient examined carefully subsequent to his dismissal. Therefore, when the report is obtained by the Tumor Clinic, usually from the local health office, that a certain patient has died, it is assumed that he has died of carcinoma. This might not be at all true. Therefore, it can be said quite frankly that these statistics on morbidity are presented to you with a very definite feeling that they may not be quite the true picture.

It is not entirely within the scope of this paper to discuss treatment, but as one notes the various combinations of radium, X-ray and operation, as done in the first years of these series, it is interesting to observe that in 1938 every case which had a carcinoma of the prostate had a transurethral resection performed, except one which was attacked perineally.

#### V. INCIDENCE AND SYMPTOMS OF CANCER OF THE PROSTATE IN 209 CASES

Dwight Wilson, M.D.

New Haven Hospital, New Haven

In order to grasp more fully the clinical picture of cancer of the prostatic gland it seemed desirable to correlate the incidence and symptoms of the cases admitted to the New Haven Hospital during the years 1921 to 1938 inclusive. The majority of the cases have a pathological diagnosis, and the remainder are classified as cases with such a diagnosis made on the various clinical methods.

The number of cases admitted from year to year in general shows an increase from seven to twenty-three. The years 1934 to 1935, for some unexplained reason, show a decided drop in admissions.

The youngest patient in this series at the onset of symptoms was 39 years of age; the oldest was 86 years of age. The average for the entire group was 64 years. However, it is significant that 172 cases or 82.33% fall in the age group of 55-80. Only 17 cases occurred before 55 and 10 cases after 80 years.

It is significant that the *duration* of symptoms previous to entry to the hospital revealed a mean period of one year. The shortest period being one month in 4 cases and over 5 years in 24 cases.



Table 1  
DURATION OF SYMPTOMS

Less than 1 year	57 cases	27.2%
1 year	39 cases	18.6%
2 years	39 cases	18.6%
3 years	13 cases	6.1%
4 years	5 cases	2.3%
5 years	16 cases	7.6%
Over 5 years	24 cases	11.6%
Not stated	16 cases	7.6%

Symptoms were present for less than one year in 27.2% while 72.8% had symptoms lasting longer than one year.

Table 2  
RELATIONSHIP OF CHIEF COMPLAINT TO  
ACTUAL FINDINGS

Cases	Chief Complaint	Actual Findings
80	Retention	86
41	Pains in Leg, Back, Perineum	69 Leg, 64 Back 11 Perineum
18	Frequency	180
16	Hesitancy	123
12	Hematuria	105
11	Incontinence	51
7	Edema extremities	22
6	Burning	123 — 82 cases had infected bladder urine
5	Nocturia	190
3	Dribbling	70
2	Urgency	82
2	Weight loss	86
1	Decrease size stream	98
0	Intermittent stream	14

The correlation of the symptomatology shows a marked disparity in relation between the chief complaint and the actual symptoms of these patients as they present themselves for diagnosis and treatment. 80 cases had a chief complaint of *retention* of urine whereas 86 were actually found to have retention of urine. 7 patients complained of *nocturia* as a major symptom, whereas 190 were noted to have nocturia. Only 18 cases were sufficiently annoyed by *frequency* to seek relief, whereas 180 cases were found to have frequency. 16 cases sought relief because of *hesitancy* and 123 cases were found presenting this symptom. One of the most significant facts was that only 12 patients complained of *hematuria* but when this was checked 105 or well over 50% had hematuria. There were but six patients complaining of *burning* and on careful questioning 123 had burning in some form. It is particularly significant that actually 82 were found to have infection of the bladder urine. There was but one case sufficiently annoyed by decreased caliber of the urinary stream other than reten-

tion, whereas actually 98 cases were so affected. *Urgency* of urination usually considered significant was only annoying to 2 patients sufficiently to require them to seek relief, whereas 82 were found to have urgency. *Dribbling* at the end of micturition was the exciting factor in only 3 people and careful scrutiny revealed 70 were so unfortunate. Pain in more distant locations suggestive of metastases to the legs, back, hip and perineum were present in 41 patients as a major complaint. When the remainder were questioned directly, 69 had pains in the legs, 64 pains in the back and 11 had pains in the perineum. *Incontinence*, although usually offensive to patients, was present in 11 cases as a major problem. Further investigation revealed 51 persons were so affected. Not one of these patients was sufficiently troubled by intermittent stream to complain, although 14 were so troubled. Edema and swelling of the extremities, though usually recognized by the patient, was a chief complaint of but 7 people. Examination, however, revealed 22 thus affected. *Weight loss*, although considered by most physicians as serious, impressed but two cases who sought relief for this purpose, whereas 86 cases had suffered weight loss.

From the study of the chief complaint and actual symptoms it would seem that these people fail many times to recognize abnormal conditions or have a tendency to minimize their symptoms. It therefore behooves us as physicians to carefully evaluate any disorder of micturition or associated back pains in all males beyond the fifth decade if we hope to successfully cope with this malady.

## VI. DIAGNOSIS AND TREATMENT IN 209 CASES OF CANCER OF THE PROSTATE

W. Rodgers Foote, M.D.

New Haven Hospital, New Haven

The diagnosis of carcinoma of the prostate in the 209 cases presented by Dr. Dwight Wilson was made or confirmed by one or more means, namely, by rectal examination, cystoscopy, roentgenographic studies for bone metastases, or by gross and histological study, the tissue having been obtained by operation, biopsy, or autopsy.

Rectal examination proves to be the principle resource by which the clinical diagnosis of carcinoma was made. Some of the patients had

symptoms which suggested rectal examination to the physician. Seven patients were asymptomatic, and the malignancy was discovered by a routine physical examination. Diagnosis was characteristic of cancer of the prostate in 76 per cent of this series by rectal palpation. The neoplasm was encountered either as a hard nodule or as a gross replacement by hard tissue, camouflaging the outlines of the prostate and seminal vesicles, and fixation of the mass to the pelvic bones. In the majority of cases the induration had extended to the seminal vesicles.

In 38 cases the prostate did not feel malignant to the examining finger and in four cases the diagnosis was questionable. These cases were missed because of the smallness of the tumor, the relatively slight degree of induration which was not sufficient to impress the examiner, or because the tumor was obscured by benign prostatic hypertrophy. Thus, 18 per cent of patients who had negative rectal findings were proven to have cancer by pathological section.

Cystoscopic examination was helpful but not essential in the actual diagnosis in most of the cases. 56 cases of the 209 were diagnosed as carcinoma through the cystoscope, but all were also apparent cases of cancer by rectal palpation, except five. Of these latter, four showed metastases by X-ray, so that in only one case was carcinoma of the prostate primarily diagnosed by cystoscopy. However, the cystoscopic examination was indispensable in determining the degree of benign hypertrophy and in detecting intravesical extension of the tumor and other vesical complications, such as stone and diverticulum. We must remember that primary cancers of the bladder and prostate do exist together. Some times primary bladder cancers invade the prostatic gland.

Roentgenographic studies were made in 133 cases of the series. Of these, 59 were positive and 70 were negative; 4 were indeterminate for bony metastases. A rather interesting finding is that 19 patients who complained of bone pain and who were reported negative by X-ray were subsequently proven by microscopic study to have metastatic carcinoma.

Metastatic predilection was for the seminal vesicles, bladder, pelvis, spine, femur, lungs, brain and skull, in decreasing frequency. The number and percentage are quite in accord with Hinman's figures. In only two cases was exten-

sion to the rectum found when the patient presented himself. This suggests that prostatic cancer rarely causes an ulceration in the rectal mucosa. One such case terminated with this finding after fourteen years of known malignancy.

Histological confirmation was obtained in 136 cases, or 65 per cent of the series. The specimens for study were obtained at operation in 114, or 54.5 per cent of these cases, including 8 cases preceded by biopsy. In 22 cases, or 10.5 per cent, the diagnosis was confirmed by post-mortem study. In the remaining 73 cases sections were not obtained and a clinical diagnosis was made by physical and X-ray examination.

In a very appreciable proportion of the group, 24.2 per cent, diagnosis of carcinoma was made at the operating table alone. In this group, rectal palpation, roentgenographic studies and cystoscopy were negative for malignancy.

Needle biopsy in this clinic has not yet proven satisfactory. The reasons are, first, that in the hard, scirrhous cancers tissue can not be obtained; secondly, a negative biopsy does not prove the absence of a small, localized, early lesion.

	Number of cases	Living	Dead	Untraced	Average survival of dead in months	Longest survival in years
No Treatment	52	5	44	3	6	5
Suprapubic Drainage	33	0	30	3	8.3	4
One stage suprapubic enucleation	8	2	6	0	11.8	5
Two stage suprapubic enucleation	8	4	3	1	32.6	4½
Subtotal perineal excision	49	5	36	8	30	11
Total perineal prostatectomy	9	7	2	0	50	13
Radical perineal prostatectomy	4	4	0	0	—	6½
Transurethral Radium	26	6	19	1	16.4	1½
X-ray	11	1	9	1	22.6	4
Radium and X-ray	8	1	7	0	17.9	2
X-ray	1	0	1	—	1	1 mo.



Larger biopsy specimens can be readily obtained by perineal exposure of the gland. If frozen section is positive, complete excision may be done. In this clinic, where malignancy is questioned, it is a routine custom to expose the prostate perineally and to obtain a sizeable specimen for biopsy.

The treatment of the 209 cases may best be shown by a chart.

## VII. INCIDENCE OF CANCER OF THE PROSTATE IN THE STATE OF CONNECTICUT

JOHN H. WATKINS, M.D.

Dept. of Public Health

Yale School of Medicine, New Haven

In Connecticut in 1920, 24 deaths from cancer of the prostate were reported. In 1925 there were 48 and in 1935 to 1937 an average of 114 deaths annually were recorded. This increase, for the most part, appears to be due to better diagnosis of the disease. That this is true and that considerable room exists for further improvement is indicated by the figures of Hirsche, who found a few years ago that of 14 autopsy diagnoses of cancer of the prostate in New Haven, six were not reported on the death certificate as such. Another cause for the increase is the so-called ageing of the population due to the decrease in the birth rate and the secession of immigration. It has been reliably estimated that in 1940 while the population of the country will have increased 7.5 per cent over that of 1930, the population aged 65 years and over will have increased by 27 per cent, or over three times as much. Thus, we see that not only has mortality from cancer of the prostate increased but that it is extremely likely to continue to do so.

Further, we have signs that prostatic cancer is a potential cause of death far greater than the mortality figures show. Both Rich of Johns Hopkins and Moore of Cornell have studied routine sections of prostates taken from consecutive autopsies. The occurrence of malignant areas, microscopic in most instances, but still malignant, were noted for various age groups. The data shown on the slide are those of Moore, but the less exact findings of Rich are in essential agreement with them. Between 15 and 20 per

cent of the prostates of men 40 to 60 years of age and between 20 and 30 per cent of those of men over 60 years show evidence of malignancy. If my rashness in applying these data to the population of Connecticut will be tolerated, indications are that between 20 and 30 thousand men over 50 in this state have malignancy of the prostate. Even if a correction for the selective factor concerned is made and the lowest figure is cut in half, a reduction hardly likely, ten thousand cases of prostatic malignancy exist in the state. The difference between these figures and the mortality figure just cited of 114 deaths is tremendous. Of course, by no means all of these potential cases can be expected to reach the killing stage. Cancer of the prostate is relatively slow growing and occurs among the older age groups, and these facts permit the intervention of deaths from other causes before the growth has reached a fatal stage. But if efforts pursued in other fields of medicine are reasonably successful at the older ages of life, this intervention will be lessened and more fatalities of prostatic cancer can be expected.

Turning our attention now to the death rate from this disease, let us note the trend in Connecticut. As was true with the number of deaths, this increase in the death rate can be attributed both to the increase in diagnosis and to the ageing of the population. But the increase in the death rate still occurs when the latter factor has been removed. The standardized death rates from prostatic cancer, that is the death rates with the age factor removed, from the experience of the Metropolitan Life Insurance Company's Industrial Department can be taken as fairly typical of the country at large. This trend, it should be pointed out, is not the same as that for other sites of the disease. It is notable that the annual increase in cancer of the prostate, 5.4 per cent, is exceeded only by that for cancer of the pancreas and for the lung and pleura.

So we can say that both the actual deaths from prostatic cancer and the death rate have increased; and the indications are that they will continue to do so, the deaths by virtue of better diagnosis and the ageing of the population and the standardized death rate by better diagnosis. We have the rather paradoxical situation that, although there are no signs that cancer of the prostate as a disease is increasing as such, both



the number of cases and the mortality rate from it will continue to rise.

## VIII. HOW CANCER OF THE PROSTATE GROWS

W. EDWIN LAWRENCE, M.D.  
New Haven Hospital, New Haven

In discussing the problem, How Cancer of the Prostate Grows, one finds four questions which should be considered: first, where does it begin; second, how does it develop; third, how does it metastasize; and, fourth, why do metastases to bone show opaque X-ray shadows rather than non-opaque?

¶ Carcinoma of the prostate is a slow growing malignant disease and may be confined for a long time in the capsule of the prostate. It may also be held for a long period within a benign overgrowth and suddenly burst forth to cause acute, complete urinary retention. It most commonly grows into the seminal vesicles and to the pelvic bones. It also extends behind and into the base of the bladder causing obstruction of the ureters and death from uremia and infection. It may extend forward into the bulbous urethra producing erections many years after physiological activities have passed. Rarely it produces ulceration in the rectal mucous membranes, causing bleeding.

It is universally recognized that carcinoma of the prostate almost invariably originates in the posterior lobe. It is seen occasionally arising in the lateral lobes but is rare in the anterior lobe and as far as we are aware there are no authenticated reports of its starting in the median lobe. It occurs infrequently in a prostatic cyst and in this location is extremely malignant.

The problem of how carcinoma of the prostate develops is a point for considerable argument, discussion centering upon the problem of whether or not it arises from hypertrophied tissue. It is impossible to draw positive conclusions about the frequency of carcinoma associated with overgrowth because of the divergency of statistics. One finds statements in the literature to the effect that cancer is a process independent of benign overgrowth and that there is no evidence that it develops from benign prostatic hypertrophy. However, on the other hand, there has been a recent report from Germany by Hryntshak in which the author has attempted to prove

that carcinoma can and does originate from hypertrophied portions of the gland. In studying his microscopic sections he found that foci of regeneration were present in a great number of cases of hyperplasia and that these centers of regeneration were always present in early cases of carcinoma. The regenerations in the true prostatic gland as well as in the hyperplastic parts often developed out of inflammatory processes but probably often also through traumatic causes. Groups of tubules seem to go through repeated regeneration phases, and all along these constantly repeated regeneration cycles these tubules become more and more irregular and atypical. There are always several areas of regeneration in the hyperplasia, especially in the peripheral zones. These individual foci of carcinoma grow into each other and fuse to form the well-known picture of cancer of the prostate. He believes that he has been able to prove that it is possible to establish an uninterrupted chain of intermediate phases between regeneration and carcinoma.

His theory is intriguing and may be correct, but his illustrations are not conclusive and his paper leaves one with the impression that, although his work may be a step in the right direction, definite proof that carcinoma arises by repeated processes of tubule regeneration has not yet been established.

How does carcinoma of the prostate metastasize? The great frequency of skeletal metastases is a prominent feature of the disease. The bones most frequently involved are the pelvic bones, sacrum and lumbar vertebrae. The frequent metastases to these bones has been variously explained by the theory of centrifugal spread from the primary source; by the theory of blood borne emboli; and by the theory that the lymphatics of the ligaments of the spinal laminae may be important means of extension of the tumor from one portion of the axial skeleton to another.

Roger Graves of the Pondville State Hospital for Cancer has recently reported on a study of the osseous metastases of this disease and has concluded that the preponderance of metastatic lesions in the pelvis and lower spine is due to the distribution of nerves and the conduction of the tumor cells along the perineural lymphatics. This is a prominent feature because of the rich nerve supply in the prostate, its capsule and in

the adjacent tissues. When these lymphatics are invaded, the tumor may spread by permeation with maintenance of continuity or rarely by emboli. Its occurrence may be suggested clinically by the presence of pain.

These perineural lymphatics may be regarded as pathways leading the metastatic cancer into contact with cortical bone. From this point, growth through the ostia and invasion of bone is a simple process. In Graves' sections, direct invasion of bone was repeatedly demonstrated. A possible explanation of why metastases from carcinoma of the prostate may give symptoms before X-ray evidence of their existence can be obtained is that after advancing along the perineural lymphatics, the metastatic carcinoma is developing in the lymphatic plexus closely related to periosteum and cortical bone. Graves believes that the assumption is justified that the osteosclerotic nature of the metastases is due to the slow growth of the metastatic lesions which permits the pressure of the growing tumor to stimulate osteoblasts to increased activity rather than to destroy the osteoblasts and their products.

It must be emphasized, however, that prostatic cancer also metastasizes by invasion of the usual lymphatic channels and by blood borne emboli.

### Summary

1. Carcinoma of the prostate arises in a large majority of cases in the posterior lobe; occasionally in the lateral and anterior lobes; and rarely, if at all, in the median lobe. It rarely arises in a prostatic cyst.

2. There is suggestive but not proven evidence that it may develop from repeated regeneration of prostatic tubules in benign overgrowth.

3. Although metastasizing through blood vessels and the usual lymph channels, a most important mode is the extension along the perineural lymphatics.

4. Stimulated activity of the osteoblasts by slowly growing metastatic tumor may account for the osteosclerotic nature of the metastases.

## IX. THE EARLY DIAGNOSIS OF CANCER OF THE PROSTATE

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There is nothing characteristic about the symptoms of cancer of the prostate. The symp-

toms of frequency, hematuria, difficulty of urination and retention are suggestive in every respect of a benign bladder neck obstruction. In many cases, there are no symptoms referable to the urinary tract. In rare cases, the first symptoms presented are those of metastasis in distant parts of the body, such as a bone tumor or a fracture which has occurred after a slight trauma.

In making a diagnosis of cancer of the prostate, it is necessary to understand a few of the characteristics of the disease.

1. Carcinoma usually begins in the posterior lobe of the prostate, which can be palpated upon rectal examination.

2. A small percentage of cases begin in the anterior lobes of the prostate, which can not be palpated by rectal examination.

3. 50 to 80 per cent of cases of carcinoma of the prostate are associated with hypertrophy of the prostate.

4. The usual prostatic operation, either resection or enucleation, does not prevent the development of carcinoma in the posterior lobe.

The diagnosis of advanced carcinoma of the prostate is usually easily made. In the typical case one or both lobes of the prostate feel stony hard upon rectal examination. This hardness usually extends up over the vesicles and the prostate is fixed to the pelvis. When this hardness extends to the seminal vesicles or the intravesicular angle and the periphery of the posterior lobe of the prostate, the boundaries between the prostate, vesicles and pelvis may be indistinguishable. Extension to the rectal and perirectal tissues is indicated by induration and fixation. In 25 per cent of cases, X-ray of the spine and pelvis will show evidence of metastasis. Only occasionally will the carcinoma feel soft, when it has gradated to the soft medullary tumor.

It is the diagnosis of early carcinoma of the prostate which should interest us most, as these are the patients who should be relieved. The early diagnosis can only be accomplished by making a rectal examination a part of the general physical examination. Any hard, indurated area found in the prostate should be looked upon with suspicion.

The early carcinoma of the prostate may be confused, first, with chronic prostatitis. However, in chronic prostatitis the induration is usually diffuse and not of stony character. A



course of treatment by massage will usually differentiate the two lesions. The expression of bloody prostatic fluid following massage may favor carcinoma of the prostate. Secondly, it may be confused with prostatic calculi. The differential diagnosis can be made, because when calculi are present one feels isolated nodules of a diffuse or stone-like consistency and X-ray will reveal shadows due to calculi. Last, it may be diagnosed as tuberculosis of the prostate. Here there are also isolated nodules or a more diffuse induration, but the induration is never as marked as in malignancy. A primary prostatic tuberculosis is very rare, and, as a rule, there will be a primary focus in the epididymis or kidney.

Aspiration biopsy has been recommended. Reports from the Memorial Hospital in New York City show that a diagnosis of carcinoma can be made in a large number of cases. This requires special technique and a pathologist trained in this particular work. Our experience with this method has not been satisfactory except in the advanced cases. It is our belief that a suspicious nodule in the prostate should be treated in the same way as a nodule in the mammary gland. The prostate should be exposed through the perineum and a specimen obtained for frozen section. This procedure will give an exact diagnosis and the proper treatment can be performed at the time.

## X. PATHOLOGY OF CARCINOMA OF THE PROSTATE

Averill A. Liebow and Robert Tennant

In a preliminary study of the histology of carcinoma of the prostate an attempt was made to grade the tumors and to correlate the grading with duration of life. The grading was established on the basis of a consideration of the deviation from the typical in the arrangement and morphology of the cells and of the number of mitoses. The most differentiated tumors were assigned the grade one and the least differentiated the grade three. Certain unusual types such as a cystadeno carcinoma and several foam-cell carcinomas were observed. Since these were difficult to grade by the method employed, further study of a group containing significant numbers is necessary. It was interesting to note that some of the least anaplastic growths showed extension to perineural lymphatics at an

early stage. Only material from patients who survived one month or longer after operation was used. The correlation of grade and survival is summarized in the table.

Grade	No. of Patients	Range of Survival in months	Average Survival Time in Months	Patients Living
I	10	4-50	26.7	0
II	13	1-48	22.0	1 at 6½ years 1 at 5 months
III	6	1-20	11.1	1 at 55 months
Total	29			

The apparently shorter survival of patients with grade II carcinoma suggests the desirability of studying a larger group.

Benign overgrowth was coexistent with carcinoma in 7 of the 29 cases. This incidence of about 20% is comparable with that usually cited in larger series. These patients survived an average of 28 months whereas the 22 who had no benign overgrowth lived an average of 22.9 months after biopsy.

It is possible that in the consideration of any individual case the extent of the lesion at the time the patient presents himself for treatment is of greater prognostic significance than the histological grading. This particularly in the instance of an organ as small as the prostate, as intimately bound to neighboring structures and as abundantly supplied with lymphatics.

## XI. SURGICAL TREATMENT OF CANCER OF THE PROSTATE

CLYDE L. DEMING, M.D.

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Charles H. Mayo has said that whatever we do for cancer of the prostate it will be wrong. To admit defeat before we begin treatment is contrary to the philosophy of modern medicine. There has been a tendency to shun cases of cancer of the prostate, to sidetrack them, or to relegate them to some one else for treatment. Too much has been written and said about surgical relief of these patients and too little has been done to cure them. Their numbers are apparently increasing. Even with relief of urinary



obstructions, hundred of them end their days suffering frightfully from metastases to the pelvis and back. There are hardly a half dozen physicians in this land who are making any effort whatsoever to cure cancer of the prostate.

It is unfortunate that prostatic cancer is not more radio-responsive. Deep X-ray therapy relieves some back pains, but cures can not be credited to this method of treatment. The application of radium by different routes, via the urethra and rectum, suprapubically through a cystostomy wound, and interstitially by perineal exposure of the gland, has so far been of little value. Surgery offers a greater opportunity.

The surgical treatment for prostatic cancer may be applied in two ways: (1) palliative for relief of urinary distress, and (2) for cure.

1. Palliative:
  - a. Suprapubic drainage.
  - b. Suprapubic excision of obstructing portion.
  - c. Suprapubic cauterization of obstructing portion.
  - d. Suprapubic enucleation of main portion.
  - e. Urethral punch.
  - f. Urethral fulguration.
  - g. Urethral resection.
  - h. Perineal subtotal prostatectomy.
2. Cure:

Perineal — { Hemiprostatectomy  
Total Prostatectomy  
Radical prostatectomy

From 1921 to 1939, 209 cases of cancer of the prostate have been seen at the New Haven Hospital. 137 of these cases were treated surgically by various methods. There have been nine operative deaths. Six followed suprapubic drainage alone; five of these patients had pneumonia and one had septicemia. One death by septicemia followed transurethral resection. Two deaths followed subtotal palliative procedures, one from pulmonary embolus and the other from pneumonia. In only thirteen cases was there a surgical attempt made to cure the cancer of the prostate, as the cancer was too far advanced in the other cases. There were no operative deaths in this group. Two are now dead, having lived six and one-half years and sixteen months respectively. Both died of metastases. Of the living, two have metastases; four are well, thirteen, seven and one-half, seven, and six and one-half years post-operatively and do not have

metastases. Five cases have been operated on too recently to state results.

The literature is full of reports of cases treated with transurethral resection; but there is not a single word about a cure or an attempt to cure the disease. To limit one's attack upon a fatal disease of slow growth is a disgrace to our profession. Many clinics make no attempt to cure cancer of the prostate. Their reports advocate suprapubic drainage and leave the future of the patient to some distant physician who can give only anodynes. Doctors who advocate transurethral surgery hope only to give relief of obstruction. This method of treatment does not lessen the frequency of urination except in a few cases. To remove the protective mucous membrane from the posterior urethra makes some patients more uncomfortable and hastens their death. In selected cases, transurethral surgery may be well applied, especially in the treatment of those patients who already have a lesion which has ulcerated into the urethra and who are beyond the prospect of cure by any method. The suprapubic approach to cancer of the prostate can rarely be well applied because of the difficulty in enucleation. Infiltrated benign overgrowths are sometimes removed without difficulty, but the suprapubic operation can not be applied to cure cancer of the prostate. We rely on suprapubic drainage for those patients in the advanced stages of the disease who have a large growth, pains in the back, or bony metastases demonstrable by X-ray, and for those cases in which the cancer has grown into the bulbous urethra.

The crux of the treatment for cancer of the prostate lies in the early diagnosis of the disease and total excision of the lesion, either by hemiprostatectomy, total prostatectomy, or radical excision of the prostate, seminal vesicles and bladder neck. Young and Smith claim 50 per cent cures by this surgical procedure. The results in our small group of cases should certainly equal these results. The perineal route furnishes the only adequate approach for diagnosis by biopsy and radical cure. We are ashamed and humiliated by our results. The only way to improve our treatment of cancer of the prostate is to urge men beyond the age of 50 years to have yearly rectal examinations, to educate physicians to recognize early lesions, and to make a

(Continued on Page 325)

# State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

## Mortality In 1938

WILLIAM C. WELLING\*

Hartford, Conn.

The health record of 1938 was remarkable in many ways. In the first place the deaths of Connecticut residents occurring within the borders of the state, give a provisional mortality rate of 9.7 deaths per 1,000 population. This is the lowest general death rate on record and may be compared with the next lowest rate of 9.9 established in 1937.

Among each 1,000 living births recorded during the year, 36.3 children under one year of age died. In numbers, 849 infants died; there were 23,397 living births. The number of births gives a birth rate of 13.1 per 1,000 population, which is the highest rate since 1933. The rate of 36.3 is the record low.

Typhoid fever caused 5 deaths, the resulting death rate being 0.3 per 100,000 population. Month after month of the year went by until in November there was the only death due to measles for the entire calendar year. The actual death rate due to measles was .06 but as rates are carried to the nearest tenth the rate is 0.1 per 100,000 population.

Scarlet fever, whooping cough and diphtheria, in this order, contributed 4, 13, and 12 deaths with respective death rates of 0.2, 0.7, and 0.7 per 100,000 population. The diphtheria death rate was 1.4 in 1937.

All forms of tuberculosis yielded a mortality of 613 deaths and a death rate of 34.2, the lowest on record. What has been accomplished in lowering this death rate may be noted from the death rate of 244.0 per 100,000 population for tuberculosis in all its forms, year of 1885.

Cancer (all forms) with 2431 deaths and a rate of 135.9 established a record high.

There was not a single death due to poliomyelitis and only 18 cases were reported.

One of the outstanding features of the year was the marked reduction in deaths due to some form of pneumonia. There were 865 such deaths, and not since 1889 have the pneumonia deaths in Connecticut been less than 1,000 in any year. The death rate of 48.4 is the record low, the next best rate being 62.9 per 100,000 population made in 1934. It is confidently expected that early typing and the increased use of serum have made this remarkable record possible.

In 1937 there was a very significant drop in maternal mortality, 63 deaths being charged to the puerperal state and a resultant death rate of 2.8 per 1,000 living births.

In 1938 there were, 67 deaths, and a death rate of 2.9 per 1000 living births.

Complete figures for all causes of death as contained in the International List of Causes of Death are not as yet available for 1938. However certain provisional results may be shown, so that 1938 may be compared with 1937, for increase or decrease.

<i>Cause of Death</i>	1938	1937	<i>In-crease</i>	<i>De-crease</i>
Organic Heart Disease . . . . .	4295	4084	211	
Cancer . . . . .	2431	2223	208	
Apoplexy . . . . .	1488	1488		
Acute and Chronic Nephritis. . . . .	1377	1398		21
Accidents . . . . .	1213	1218		5
Pneumonia (all forms) . . . . .	865	1115		250
Tuberculosis (all forms) . . . . .	613	651		38
Diabetes . . . . .	509	538		29
Totals . . . . .	12791	12715	419	343
Net Increase—76				

Included in the accidental deaths for 1938 were 340 deaths caused by automobile accidents. In 1937, there were 419 such deaths, a reduction of 79.

\*Director, Bureau of Vital Statistics



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## • Editorials •

### ANOTHER MILESTONE PASSED

The House of Delegates in voting to employ a full time physician Secretary for the Society has acted both wisely and well. There are many in the Society who felt a keen disappointment three years ago when the first real effort to establish a full time Secretary met defeat. Conditions in our State and in our Nation demanded a more efficient organization for the medical profession of Connecticut but the medical profession itself was not ready to fill the need. During the intervening three years a steady process of evolution has been taking place within our Society. The new office in New Haven has found its routine work grow more rapidly than the keenest among us anticipated, its interest spread to many phases of health work and its opportunities for leadership arrive from unexpected and seemingly unrelated sources. The personnel of the office has been increased to meet these demands and, what is most gratifying to the Council, the influence of our Society is becoming a vital factor even beyond the limits of our State. To the present incumbent of the secretarial chair must be given in a large measure the credit for these developments.

The proposal presented to the House of Delegates in 1936 to establish a full time secretary was decisively defeated. The group sponsoring this change was looked upon as the radical element in the Society, New Dealers if you will, not safe as leaders in this old New England state. The compromise attained affording a separate office for the Society and a full time stenographer, a part time physician executive secretary who has since assumed the duties of the legislative secretary, a monthly Journal with a part time physician Secretary on Scientific Work functioning as its Editor,—all this has been productive of gratifying results.

Many have asked the question, "Why do we need more efficiency, more expense, more equipment as an organization?" The best reply to such questions is to be found in the address recently delivered by one of our retiring County Association presidents. "If the best interests of



our profession are to be served during these times of confusing change, medical Associations such as ours can no longer remain quiescent laissez faire organizations with their future behind them. Our problems are no longer wholly within ourselves. American medicine has reached the stage where it is playing a vital role in the nation's economy. We have a public and social responsibility that must be met, not to see those responsibilities reflects upon our intelligence, to shirk them will surely bring us discredit."

The cost of this change in carrying on our State Medical Society makes a considerable increase in dues necessary. Many object to increased taxation. It seems to have become a habit today with governments; the thought is implied if not too often expressed that we are suffering from the contagion of spending. Perhaps we can lay some of our increase in secretarial work at the door of the New Deal. At least the present regime in Washington has done much to disenshroud our profession of its priestly gown and to leave us no longer a law unto ourselves.

We must bear in mind one very important fact, however, that it is not a question of fifteen dollars a member per year but rather of just where you and I wish to find our Society in the league of organizations striving to improve the Nation's health. Are we going to accept our opportunity to engage with other organizations and agencies in intelligent united effort toward better health conditions, higher standards of living, lower morbidity and mortality rates; in other words, are we going to be reckoned with as a power in the endeavor to make this a better country in which to live, or are we going to be content to sit by the fireside and comfortably reminisce of the horse and buggy days when our word carried the finality of judge, when labor was plentiful and arduous, and when in our ignorance we paid little or no heed to the machinations of our political friends.

There are today at least 21 state medical societies in our country represented by full time Secretaries. The number is growing each year. The demands made upon us as an organized profession are increasing. The Council of the Connecticut State Medical Society has rightly seen the vision of opportunity and appreciates the scope of service which our Society can render if it is properly equipped.

## OPTOMETRY AND OPHTHALMOLOGY

There exists a good deal of misunderstanding in the lay mind, and possibly at times in the minds of some medical men, as to the difference between an optometrist and an ophthalmologist. As generally understood, optometry is concerned with the measurement and correction of refractive errors and of muscular defects of the eyes without the use of drugs or surgery and from its very name indicates that it is not concerned with diseases of the eyes. Ophthalmology is, of course, a special branch of the practice of medicine and surgery, devoted to the study and treatment of diseases and optical defects of the eye.

It would be untrue to say that no antagonism exists between these two groups of individuals devoting their energies to ocular defects. This lack of good feeling began some years ago when some of the opticians, often with no training beyond the mechanical art of grinding lenses and adjusting spectacles, began to call themselves optometrists and to advertise free examinations for fitting glasses. Since there was no law to prevent any one from embarking upon such a business, it was inevitable that many unscrupulous individuals should enter into this new "profession" and exploit people by selling poorly fitted, and often unnecessary, glasses. Gradually the better element among the optometrists undertook to raise the standards and to improve conditions within their ranks. Several universities announced four year courses in optometry and it would seem that such a period of study would adequately prepare a student to conduct an examination of the refraction and muscle balance of whomsoever applied.

Eventually boards of examination in optometry were established in most states but when the laws regulating optometry became effective, they permitted those already in practice to continue, and so we still see the blazing Neon signs offering free examinations of the eyes and low payment costs, which attract those least able to be preyed upon. In Connecticut, for instance, the optometrists succeeded in inducing the legislature to permit them to use the title "Doctor". This, of course, helps to confuse the layman suffering from ocular trouble in his search for help and has been a source of irritation to the ophthalmologist, not that he feels superior in the possession of an M.D. degree, but that the state legislature should conceive one of

its functions to be the conferring of what are really university degrees. He can, of course, have no complaint against the holder of a degree of Doctor of Optometry, awarded by a university.

The ophthalmologist's chief objection to optometry is that one cannot study or treat one organ of the body without a knowledge of general physiology and pathology. Ocular signs and symptoms are often guide posts to serious, and sometimes fatal maladies. Another serious criticism of optometry is that it is so inextricably bound up with the merchandising of glasses. If the optometrist would charge a fee for his examination and, when glasses are needed, refer the patient to an optician, there could be no criticism on this score. Since, however, some ophthalmologists furnish glasses to patients, criticism in this respect must be charitable.

Ophthalmology, like all other specialties, has suffered in the past from the handicap of poorly trained members. The dissatisfied general practitioner who decides to specialize and spends three months in New York or abroad cannot have the training necessary for one to practice so delicate and important a branch of medicine. Fortunately such conditions are rapidly changing and the younger generation of ophthalmologists are in general very much better qualified than was formerly the case. While optometrists unquestionably get a great many patients who would otherwise consult an ophthalmologist, a great percentage of people will prefer to be treated by the eye specialist with a broad medical training who can correlate their general physical condition with any changes found in the eye, as well as prescribe glasses for the correction of optical defects.

The number of optometrists in the United States is far greater than the number of ophthalmologists and optometry has apparently come to stay. It would seem, therefore, that we should endeavor to fulfill the Biblical injunction "If it be possible, as much as lieth in you, live peaceably with all men." Certainly nothing will be gained by a spirit of animosity and the fomenting of dissensions.

E.M.B.

#### LICENSURE OF GRADUATES OF FOREIGN MEDICAL SCHOOLS

A study of existing state regulations discloses a lack of uniformity in the requirements for

licensure of graduates of foreign medical colleges. Twenty-three states require full United States citizenship before a candidate may be admitted to state licensure examination. In twelve other states a candidate is required to present first papers for citizenship. Regulations in South Carolina and Wyoming are the most stringent of all, for in these states graduates of foreign medical schools are not accepted for examination under any circumstances. Nine states and the District of Columbia have no regulations in regard to citizenship. In several other states the fourth year of training must be repeated in an approved medical school in the United States or an internship served in an acceptable hospital. Several states ask that graduates from foreign schools be licensed by the National Board of Medical Examiners before they are admitted to state licensure.

The Federation of State Medical Boards of the United States has concluded that because of the many factors related to the economic welfare of American physicians, the high ethical standards of medical practice and the responsibility for the well-being of the citizens of any community justify the assumption that it is both expedient and advisable to require citizenship as a prerequisite to the practice of medicine in this country.

C. B.



#### AN OPPORTUNITY WORTH UTILIZING

An American Congress on Obstetrics and Gynecology will be held in Cleveland, Ohio, September 11th to 15th, 1939 to study present day problems on Obstetrics and Gynecology, and to make some attempt at the solution of these problems.

The purpose of the Congress: "To present a program of our present day medical, nursing and health problems from a scientific, practical, educational and economical viewpoint so far as they relate to human reproduction and maternal and neo-natal care." It is the desire of the Committee on this Congress that all those persons interested in any way in the subject of Obstetrics, should attend the various meetings, or at least contribute to the support of this worthy undertaking. The subjects to be discussed are not entirely medical and considerable time will be given to legal aspects, humanitarian, sociological



and ethical aspects of the various subjects under discussion. It is hoped, therefore, that not only will the medical profession itself whole heartedly enter into this project, but that nurses, public health workers, hospital superintendents and those indirectly concerned may become interested.

The morning sessions will consist of a series of interesting papers followed by a round table discussion. Both afternoon and evening sessions will be devoted to those subjects closely allied to Obstetrics itself, but of particular interest to nurses and public health workers. Elaborate plans have been made for a scientific and educational exhibit, as well as a most complete technical or commercial display.

The membership fee is \$5.00 which includes a year's membership in the American Committee on Maternal Welfare and registration in the Congress in September. To date, only twenty-two from the State of Connecticut have signed up for the Congress. It is hoped that those in our state who have a sincere interest either directly or indirectly in Obstetrical problems, will without further delay make application for the Congress.

J. H. H.

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#### APPARENTLY THEY DON'T WANT IT

At the meeting of the house of delegates of the Medical Society of the State of Pennsylvania, Oct. 3-6, *The Journal of the American Medical Association* for Jan. 28 says it was reported that Dauphin County organized a County Medical and County Dental Society Bureau directed by an experienced welfare worker and including on its staff a medical-social worker and offered the people of the county a free choice medical or dental service care on a budgeted or partial fee basis, or without any charge if properly certified.

Disappointed with the very slight response, the bureau at its own expense, carried advertisements in three daily newspapers and later for ten consecutive weeks a series of advertisements with accompanying explanatory articles in a labor journal of the county reaching 20,000 employed persons. Again the results were negligible.

It is quite apparent that between existing hospitals, dispensaries, clinics, physicians and dentists in private practice, without mentioning

other well organized institutions and agencies, the present day sickness needs, both preventive and corrective, of the people of this populous county are being met as those in need of such services will seek and accept them.

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#### COMMERCIAL DIAPER SERVICE PROVIDES BETTER STERILIZED GARMENTS

The rapidly growing commercial diaper service not only saves time and strength for thousands of mothers but also provides safer, better sterilized garments for their babies, Elizabeth Dobson, Chicago, observes in *Hygeia*, *The Health Magazine* for May.

"In an investigation of washing methods used in private homes," she says, "it was found that after the cold rinse or soak, hot suds and three rinses usually employed, the average count of bacteria per cubic centimeter of wash water was 168,388, as compared to absolute zero when the commercial formulas were used.

"A recent visit to a diaper laundry disclosed that when the soiled diapers are brought into the plant they are emptied directly from the paper bags into huge metal washers. They are then washed, sterilized and rinsed numerous times in soft filtered water. In all there are eleven different operations.

"In addition to the use of formulas to destroy bacteria, one step in the washing process rids the garments of lime, soap and other residue. Diaper rash is practically unknown among babies for whom they are used.

"The diapers are dried in hot air at 180 F. During all operations they are untouched by human hands.

"When a mother orders the diaper service, a supply of new, excellent quality garments sufficient for the baby's needs is assigned to him. They are individually marked and registered so that during his 'diaper life' they are used exclusively by him.

The diaper laundering industry, started in 1931, now embraces some fifty firms in the larger cities.



# From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street

New Haven

## COUNTY ASSOCIATION MEETINGS

The annual meetings of the various county associations were held during April. The press of legislative affairs in Hartford kept the Secretary from attending all of the meetings but reports from them showed unusual attendance and enthusiasm. At the Middlesex County meeting which the Secretary did attend, they had nearly 100 per cent of the membership in attendance. The Fairfield County meeting was also largely attended and at the annual dinner of the Association, Doctor Albert E. Austin, a member of the Fairfield County Association who is the representative in the United States Congress from the 4th district, spoke most emphatically in opposition to the Wagner health bill now pending before the United States Senate.

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## COUNTY ASSOCIATION OFFICERS

### Fairfield

President: William M. Stahl  
Vice-Pres: Berkley M. Parmelee  
Secretary: J. Grady Booe  
Councilor: James D. Gold

### Hartford

President: Henry N. Costello  
Vice-Pres: William T. Morrissey  
Secretary: Frank T. Oberg  
Councilor: Edward J. Whalen

### Litchfield

President: Edwin C. Reade  
Vice-Pres: Roy V. Sanderson  
Secretary: W. Bradford Walker  
Councilor: Charles H. Turkington

### Middlesex

President: George M. Craig  
Vice-Pres: Carl Chase  
Secretary: Charles Russman  
Councilor: Roy L. Leak

### New Haven

President: Cole B. Gibson  
Vice-Pres: J. Harold Root  
Secretary: Ralph E. McDonnell  
Councilor: Thomas P. Murdock

## New London

President: Edmund L. Douglass  
Vice-Pres: Clarence G. Thompson  
Secretary: Carl H. Wies  
Councilor: George H. Gildersleeve

## Tolland

President: Alfred Schiavetti  
Vice-Pres: William Schneider  
Secretary: Francis H. Burke  
Councilor: Charles T. LaMoure

## Windham

President: Cecil R. Garcin  
Vice-Pres: Morton Arnold  
Secretary: Ralph L. Gilman  
Councilor: Robert C. Paine

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## HOSPITAL SERVICE BILL BECOMES LAW

Senate Bill 57, an enabling act for the control of hospital service corporations, which was written by the conference called by Governor Cross last fall and in which members of this Society participated, has been passed by the House and Senate and become a law. It is sensible and far seeing legislation and places the control of corporations providing hospital service on a pre-paid basis under the supervision and control of the Insurance Commissioner of the State. Under the law such corporations will be permitted to write contracts with hospitals that have been approved for this purpose by the State Medical Examining Boards. Provision is also made in the law for annual auditing of the finances of such corporations and it prescribes how surpluses may be invested. It also exempts such corporations from state and local taxes.

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## STUDY OF THE COST OF MEDICAL SERVICE

The study of the cost of medical service for hospitalized patients that was authorized by the Council some months ago is progressing well. The study is being made by a committee consisting of Samuel C. Hørvey, James R. Miller,

Thomas P. Murdock and the Secretary. Doctor Harvey is directing the study which is being made in cooperation with Mr. Watkins of the Department of Public Health of Yale University. Some interesting facts have been already developed from this study and when it is completed, it should be richly informative. The committee wishes to thank the physicians in various parts of the State who have aided in the study.



## HIGH LIGHTS FROM HOUSE OF DELEGATES

147th Annual Meeting, Connecticut  
State Medical Society  
New Haven, May 24, 1939

It was unanimously voted to employ a full time Executive Secretary commencing January 1, 1940, as recommended by the Council and for this purpose the annual dues for the year 1940 were set at fifteen dollars per member.

The Society will hold its next annual meeting in 1940 in Hartford and its 150th Annual meeting in 1942 in Middletown, the latter being the place of its first meeting on October 9, 1792.

The petition for the formation of a Section on Physical Therapy was approved and the formation of this section authorized.

The request from the Connecticut Hospital Association that it be permitted to use the Journal as its official publication was approved and the Council empowered to complete financial arrangements with the Connecticut Hospital Association for this purpose.

Several amendments to the By-laws of the Society were adopted. Those of most interest are the nomination and election of officers during the first session of the House of Delegates at the Annual Meeting, the addition of a Committee on Industrial Health, and the pro-rating of the dues of newly elected members.

It was voted that the President appoint a Committee of three to study the Osteopathic physician's status and report to the House of Delegates at the Annual Meeting in 1940.

The Council was authorized to prepare an amendment to the By-laws providing for the exemption from payment of dues of members of the Society of over forty years standing, if so requested by such members.

The Council was directed to inquire into the possibilities of collecting the State Society dues through the State Society's office directly instead of by the various County Associations.

The Council was directed to prepare a by-law providing for the payment of dues of indigent members of the Society in some other manner than from the O. C. Smith Fund.

It was voted to advise the Program Committee to prepare a mid-winter meeting program such as was held during the past year with an outstanding speaker as guest.

It was voted that the President appoint a Committee of five to investigate pre-paid medical care and report to the Annual Meeting of the House of Delegates in 1940.

It was voted to instruct the Committee on Public Relations to embark upon a program with a view to informing the public on medical problems.

The following officers were elected for the year 1939-1940:

President	Joseph I. Linde, New Haven
President-elect	Arthur B. Landry, Hartford
First Vice President	Charles E. Sanford, New Haven
Second Vice President	W. Bradford Walker, Cornwall
Executive Secretary	Creighton Barker, New Haven
Legislative Secretary	Creighton Barker, New Haven
Secretary on Scientific Work and Editor of the Journal	Stanley B. Weld, Hartford
Treasurer	James R. Miller, Hartford
Delegate to A.M.A. for term of two years	George Blumer, New Haven
Alternate delegate to A.M.A. for term of 2 years	James R. Miller, Hartford

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**RESOLUTIONS ON THE NATIONAL  
HEALTH BILL OF 1939 (S. 1620)  
also known as the Wagner Bill**

Whereas the **purposes** of the National Health Bill of 1939, namely the more adequate provision for medical health, the prevention and control of disease, maternal and child welfare, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance and training of personnel, should have the approval of The Connecticut State Medical Society, and

Whereas the **methods** proposed for bringing these purposes about are open to objection for the following reasons:

1. The control of the complete program by several independent federal agencies, whereas the medical profession through the American Medical Association has favored a single federal department of health under an officer of cabinet rank.

2. The complete control of cooperating state agencies by the federal agencies which are given authority to disapprove state plans and to withhold appropriations even when plans are already in operation under federal approval.

3. The lack of recognition of the principles contained in the resolutions of the House of Delegates of the American Medical Association passed in 1938 after careful study of the many purposes covered by the bill.

4. The lack of recognition of the necessity for adequate housing and nutrition in the prevention of disease.

5. The absence of any distinction between the indigent and those with adequate means in the administration of the proposals.

6. The failure to safeguard the continued existence of the general practitioner and the basic patient-physician relationship.

Therefore be it resolved by the House of Delegates of The Connecticut State Medical Society assembled this 26th of May, 1939,

That we go on record as favoring the extension of medical service to the needy and indigent and the expansion of preventive medicine and public health where need can be shown, but by the development of a mechanism for this purpose which is within the philosophy of the American form of government and without damage to the quality of medical service.

Be it further resolved that we oppose the passage of the Wagner bill in its present form

and we favor the complete autonomy of individual states in the preparation and execution of plans to provide for such purposes as are covered in this bill. We believe that the federal government should restrict its activities to surveys, recommendations and the provision of subsidies for health activities when the need for them is demonstrated to the satisfaction of conferees representing a state and the federal agencies.

Submitted,

Arthur B. Landry

George Blumer

W. Bradford Walker

*(Committee appointed by President  
on motion of House of Delegates to  
study Wagner Bill)*

## SECTION ON Orthopedic Surgery

**Human Rheumatic Virus.** Swift and Brown of the Rockefeller Institute report animal experimental work in which a virus-like micro-organism was obtained from joint fluid, pleural exudates, and other sources suggesting a new epidemiological theory of rheumatic disease. No reports have been made to date with the human rheumatic agent. However, the possibility opens up a new field of considerable interest to the internist and the orthopedist.

**Sulfapyridine in Compound Fractures.** The use of this relatively new drug in compound fractures has been suggested by Dr. Philip Wilson of New York City. It offers fascinating possibilities in this field which may revolutionize the treatment of a compound fracture.

**Spring Meeting of the Connecticut Fracture Committee.** The Connecticut Fracture Committee of the American College of Surgeons met in Hartford on Thursday, April 27. The following program devoted to fracture treatment proved interesting and was well attended. Dr. Byron Stookey and Dr. Charles Scudder delivered most instructive papers which provoked considerable discussion from the floor. The



morning business meeting demonstrated once more the efficiency with which our state committee is functioning. Every member must get behind the program, however, so its results will be even more satisfactory.

"Dislocations of the Elbow Joint with Fracture and Displacement of the Medial Epicondyle."

Dr. Cecil R. Garcin.

"Internal Fixation in Open Fractures of the Lower Leg."

Dr. Brae Rafferty

"The Use of Stainless Steel Pins in Fractures of the Hip."

Dr. Carl W. Henze

"The Surgical Treatment of Fractures of the Spine."

Dr. Byron Stookey, New York

Discussion opened by:

Dr. R. C. Buckley

"The Treatment of Fracture of the Neck of the Femur."

Dr. Charles Scudder, Boston

Discussion opened by: Dr. J. H. T. Sweet, Jr.

"The Treatment of Fractures of Both Bones of the Leg by the Two Pin Method."

Dr. Alexander L. Bassin

"Motion Picture Illustrating Results in the Use of the Angle Bone Plate."

"Lantern Slides of the Hawley Table in the Treatment of Fractures of the Lumbodorsal and Cervical Spine."

Dr. George Hawley

Mr. William M. Greene, Director, Safety Promotion Section of the Motor Vehicle Department showed a safety motion picture entitled, "Man at the Wheel" before the beginning of the afternoon session.

**Doctor Paul P. Swett of Hartford** read a paper on "Synovectomy in Chronic Arthritis" before the newly organized Orthopedic Section of the Medical Society of the State of New York at Rochester on April 27.

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### AVITAMINOSIS

The average American diet contains an abundance of all of the vitamins. Unless something exists to interfere with their utilization, avitaminosis rarely arises.

We have observed no evidences to justify the indiscriminate prescribing of vitamins or vitamin mixtures. In the first place, most of the exploited preparations contain inadequate dosage for treatment of a true deficiency, and in the second place, the majority of people for whom such preparations are prescribed have no deficiency.

—Perry and Chinn—*Med. Ann. Dist. Col.*, Feb. 1939.

## THE NEURO-PSYCHIATRIC INSTITUTE of the HARTFORD RETREAT

### One Hundred and Fifteenth Annual Report of the Board of Managers

During the year progress has been made in the continued upbuilding of plant and equipment, the further refinement of existing facilities and the extension of the services of the Institute to an increasing number of people. One difficulty lies in trying to accept the many people who request admission and yet refrain from expanding to a size that might greatly interfere with individualized treatment for each guest, the keystone of the Institute's policy.

As the Psychiatrist-in-Chief points out in his report, the real test of efficacy is not the weekly cost per patient, but the total cost of an illness. The more intensive the treatment the more quickly the patient responds, with the result that the sickness expense is less. With this thought in mind the grounds and buildings of the institute have been regularly improved each year, so that the environment would be pleasant and contribute as much as possible to the recovery of guests. This work has continued during the year and the coming Spring should find the Campus of the Institute more beautiful than ever.

In common with other parts of New England, the Institute felt the force of the hurricane last September and lost some of its fine old trees. Otherwise we were fortunate because no structural damage was sustained, and with the co-operation of personnel members and others, there was no cessation of services at any time; all Institute roads were cleared within twelve hours, and the same night foresters and arboriculturists were busy on the grounds. Instead of merely clearing the debris, we went further and planted about ten times as many trees and shrubs as were destroyed. The net result was that within a month the Campus of the Institute had not only resumed its former park-like aspect, but had nearly three hundred new trees and shrubs planted on it. In addition, trees on the Campus were permanently identified by metal name-plates giving the scientific and popular name of each species.

At the same time the new sidewalks were in-

stalled throughout the entire Campus and all roadways were put in perfect condition so that the physical conditions of the grounds is better than ever before.

During the past year construction work has been principally directed toward the modernizing and rebuilding of the few remaining units in the Institute where such work was needed. This program included the remodelling of the entire North Hall including new hydrotherapy units, and a similar modernization of Butler Hall. Installation of new, modern serving kitchens now makes available throughout the main building the most up-to-date and convenient units for preparation and service of food. These last finished projects mark the virtual completion of a long-range program of modernizing the main building which now leaves only the South Hall to be finished.

Ives Hall, one of the social and recreational centers of the Institute has been redesigned and the interior finished with a knotty pine wood. The Golf House, another center of the social life of the Institute, has been remodelled and rebuilt, inside and out. It has been transformed into an old English building, its rough plaster and hand-hewn timbers being in conformity with other nearby buildings. The same decorative motif has been carried out in the interior, with an Ingle-Nook, before an open fireplace, over which are several large photo-murals. At one end of the Golf House, a new Hospitality Shop with modern soda bar has been installed. A somewhat similar Tuck Shop with bar has also been built in Cone Hall.

The increased activity of the Institute is reflected in the size of the personnel which is now just short of 600 persons, a sizeable economic contribution to the City of Hartford.

The health of the Institute personnel has been excellent, but because of the large number of persons involved it has been felt desirable to have a Personnel Infirmary, and this modern hospital unit for the exclusive use of personnel has been built in the main building. Also, as part of the general policy of preserving the good physical and mental health of our personnel, that they may better serve our guests, other personnel activities have been organized. The entire ground floor of the west wing of the Graduate Club has been set aside as a recreation center and social room for personnel.

The increase in personnel came about as a result of the insistent demands of those, outside the state, who had heard of the Institute and its methods. As a scientific institution it is a question whether we would have had a moral right to refuse to make our facilities available to all whom it was possible to help. At the same time, it is pertinent to note, from the Psychiatrist-in-Chief's report that no Connecticut person has been refused admission merely because he was unable to pay, and of the total number of people received during the year, more than 55% paid less than the established rate, the total of such free service being well in excess of one hundred thousand dollars during this fiscal year.

There are certain obligations devolving on a scientific center like the Institute, particularly in view of its history of more than one hundred years of service; it must maintain better than average standards and at the same time initiate original methods to improve standards of care; it must assume its share of research and investigational work and it must cooperate with the medical profession and the public by disseminating sound public health information in the field of nervous and mental illness. In short, it must go beyond what others may be doing, and thus set a pattern for others to emulate.

During the eight years since the reorganization of the Institute there has been a steady growth, both in the number of people who have been helped, and in the therapeutic facilities which are available. During this period the number of personnel has more than quadrupled, and the capacity of the Institute itself has been increased by more than one hundred beds, which addition is in itself the capacity of a good-sized institution. There have been few years which have surpassed the year just completed in disclosing consistent progress toward improved plant, refinement of methods and the assumption of broader aspects of professional responsibility.

These accomplishments are gratifying but there should be no let down in the effort to maintain the high level which has been established. Only the lack of more adequate endowments has prevented us from making our facilities more generally available.

FRANCIS W. COLE  
*Chairman*

Hartford, Connecticut  
April 19, 1939.



## Our Neighbors

### NEW YORK

On May 10 Governor Lehman vetoed the Milnor Bill which would have permitted licensed osteopaths in New York State to use instruments for minor surgical work and also to use anesthetics, antiseptics, narcotics and biological products.

In his message explaining his action, the Governor stated that the substantial value and usefulness of osteopathy is generally conceded and recognized but he called attention to the fact that many of the osteopaths practicing in New York State today "were licensed prior to the setting of the present high standards of training and have had little or no later experience in medicine or surgery." Governor Lehman expressed himself of the opinion that "legislation should provide that applicants for licenses and those who already hold licenses as osteopaths but who now desire additional powers should be required to satisfy the Board of Regents either by submitted credentials or by examination that they have had the proper instruction and training in surgical procedure and drug therapy to justify the granting of the additional powers set forth in this bill."

News has been received of the death on May 6 of Charles H. Goodrich. The Hartford County Medical Association enjoyed the privilege of listening to Dr. Goodrich as guest speaker at a recent annual meeting. Dr. Goodrich was widely known throughout New York State, having served among other capacities as president of the State Medical Society but a short time ago.

Vigorous opposition to the proposed amendment to the state education law in relation to nursing, which would provide for licensing an additional group of persons to be known as "child's nurse," is voiced by nearly 18,000 nurses as members of the New York State Nurses Association through their president, Mrs. Ethel G. Prince. This bill would provide for a new nur-

sing group to care not only for well babies but also sick babies and maternity cases under the direction of a licensed physician. The nurses believe the situation created by the passage of such a bill would be unfair to the nurses and confusing to the public.

## - NEWS -

### *from County Associations*

#### Fairfield

The fourteenth annual meeting of the Fairfield County Medical Association began with a business session at the Stratfield Hotel, Bridgeport, on Tuesday, April 11. The Society went on record as favoring an increase of dues, to enable the State Society to employ a full time Secretary who should be a physician. The after-dinner speaker, Honorable Albert E. Austin, M.D., member of the House of Representatives from the Fourth Congressional District of the State of Connecticut, spoke against pending legislation having to do with the practice of medicine and known as the Wagner Amendment to the Social Security Act. This is a bill to implement the recommendations of the President's interdepartmental committee to coordinate the health activities of the federal government. Doctor Austin discussed the implications of the bill, stressing that those who hold the purse strings would make the rules. He urged that his hearers watch for the bill, study it, and communicate their attitude to their representatives in Congress.

On April 28, Doctor Ira Cohen, attending Neurological Surgeon of Mount Sinai Hospital, spoke on the subject of "Post-Traumatic Chronic Sub-dural Accumulations of Fluid." He began with an exposition of the anatomy of the meninges, explaining the chronicity of these accumulations, and went on to a detailed consideration of diagnosis and treatment. Discussion was opened by Doctors Griffin and Brodsky.

On Thursday, May 11, the Danbury Medical Society was host to the Fairfield County Medical Association. Doctor Chester M. Jones of the Massachusetts General Hospital presented a



paper on "Diseases of the Liver." This was the last of the monthly meetings sponsored this year by the County Association, all of which have been well attended and enthusiastically received.

Congratulations to Doctor Joseph Hennessey on the birth of a daughter, and to Doctor Benjamin Horn on the arrival of an heir.

### Hartford

At the meeting of the Hartford Medical Society held on April 17, 1939, Dr. Donald Pillsbury of the University of Pennsylvania gave in detail the treatment of lues. He emphasized the necessity of early and persistent treatment with arsphenamine and bismuth with an observation period extending over three years. Further, he expressed the opinion that potassium iodide and mercury are of no value in the treatment of early lues. At some length he stressed the importance of potassium iodide in the treatment of central nervous system lues.

On Monday evening, May 1, 1939, "Some Legal Aspects of Medical Practice" was the subject of talks by Judge Daniel G. Campion and Herbert T. Weston, M.D., of the Aetna Life Insurance Company. They discussed the standard forms of liability and accident policies in detail and by practical examples emphasized some of the more important features of insurance in regard to medical practice.

Births: Nancy Burton Middlebrook to Dr. and Mrs. Louis F. Middlebrook.

Marriages: Dr. Thomas F. Murphy to Mary Scott Kane of Hartford.

Dr. Charles C. Montano to Shelia Quinn, R.N., of Hartford.

Dr. Leo T. Duffy to Mary Dunn of Hartford.

### Middlesex

The undergraduate debating club of Wesleyan University debated the subject of Socialized Medicine before the Central Medical Society recently. The subject was well presented and showed that considerable time and effort had been expended in its preparation. The presentation was well received by the medical group. No decision as to the winning team was given.

A daughter, Davida Ann, was born April 7 to Dr. and Mrs. Henry Sherwood of Durham.

A daughter, Shiela, was born April 12 to Dr. and Mrs. William E. Wrag of Middletown.

The Middlesex County Medical Association held its annual meeting on April 13. Dr. Ella A. Wilder, who conducted the meeting, retired as president. The new officers elected were Dr. G. Mansfield Craig, president; Dr. Carl C. Chase, vice-president. Dr. Charles Russman was re-elected clerk and Dr. Roy L. Leak was re-elected councilor. Dr. Louis W. Brown of Newark, N.J., was the guest speaker. His subject was "Allergy in General Practice." The after dinner speaker was Professor George M. Dutcher of the history department of Wesleyan University who gave an interesting talk on the topic, "Since Horse and Buggy Days."

The County Association received a communication from Dr. Creighton Barker, executive secretary of the State Society, in response to the County Association's invitation that the 150th meeting of the State Society be held in Middletown in 1942. This meeting would be in commemoration of the founding and first meeting of the society in Middletown one hundred and fifty years ago. Dr. Barker stated that the society's invitation had been accepted by the Council and is being referred to the House of Delegates.

Statistics for the City of Middletown show that for the second consecutive year there have been no deaths attributable to complications of pregnancy in residents of that city. One of the 333 local births during 1938 was attended by a midwife. Eighty-four per cent of deliveries took place in hospitals.

Two of 18 infant deaths occurred in newborn between the ages of one month and one year. The other sixteen deaths occurred in the first two days of life.

A tuberculin testing survey of high school students with P.P.D. showed that 22.2% of those tested reacted positively. Several of the positive reactors have been seen by their family physicians. The rest will have x-ray studies of the chest at Undercliff Sanatorium. The family of each positive reactor will be visited and urged to have the family doctor examine the remaining members.

The Middletown Board of Health has discontinued the use of the Middlesex Hospital laboratory for the serological diagnosis of syphilis. All blood samples that physicians wish to have tested may be deposited in a container in the lobby of the Municipal building and these are sent daily to the laboratories of the Connecticut State Department of Health. This procedure, it is announced, is to be followed for a trial period of one year. The Hospital laboratory is being used for other types of diagnostic procedures.

The Middlesex Hospital has announced that following the retirement of its present radiologist, Dr. James A. Murphy, a full time radiologist will be employed. Dr. Willard E. Buckley, a graduate of Boston University Medical School and at present a resident at the New Haven Hospital, will begin his duties June 1. The appointment represents a distinct change in policy in the administration of the x-ray department.

Dr. Emily Pierson, health officer of Cromwell, has announced a series of 4 lectures on medical subjects of interest to the general public. These are to be held at the Nathaniel White School during May and June. Dr. David R. Lyman will speak on Tuberculosis, Dr. N. Herbert Bailey on Contagious Diseases in Childhood, Dr. Ashley W. Oughterson on Cancer, and Dr. H. M. Marvin on Heart Disease.

The Central Medical Society met on May 8 at the Connecticut State Hospital. Dr. F. E. Tracy spoke on bronchial asthma and the staff physicians of the Hospital under the chairmanship of Dr. H. O. Colomb presented a symposium on Simmond's disease and spontaneous hypoglycemia.

Dr. Roy L. Leak supervised the removal of the contents of the cornerstone during the demolition of the old Administration building. This building was one of the early units of the Connecticut State Hospital and was built in 1867. The list of contents of the cornerstone box follows: A copy of the Connecticut Register, 1867; an Episcopal Prayer Book; a Bible; list of electors of the First and Second districts of Middletown and of the Fourth district of Westfield, April, 1867; a report on the Commission of Incurable Insane, stating that there were 706 insane in Connecticut in 1867; the first report of the Board

of Trustees of the hospital; a roll or register of the various state officials; annual report of Wesleyan university, 1866-1867; report of Berkeley Divinity, 1866; copy of the New York Times, June 19, 1867; copy of New York Herald, June 19, 1867; copy of the Hartford Morning Post, June 20, 1867; copy of "Our Country," dated June 15, 1867, which was published every Saturday in Middletown; copy of the Constitution, June 19, 1867, a paper published here; copy of the invitation and program of the exercises held when the box was filled, June 20, 1867; a photograph of Rev. C. T. Woodruff, secretary of the Board of Trustees; a photograph of Abraham Sheu, the institution's first superintendent; a handwritten copy of the Legislative Act passed which incorporated the hospital; a stamped envelope; money; a one dollar bill; also fifty cents, twenty-five cents and 10-cents, all in the small "shin-plaster" bills of that time; also a three-cent piece and a two-cent piece; stamps included a two-cent, a three-cent and a five-cent stamp; a parchment document handwritten in script, giving the various names of trustees, some data of the state and other information.

Dr. F. Erwin Tracy of Durham and Middletown, attend the recent Convention of the American Medical Association in St. Louis.

Members of the Medical Board at the Middlesex Hospital enjoyed a golf tournament at the Edgewood Country Club on May 11. It is reported that the score keeper was thrown in the lake.

### New Haven

The New Haven Medical Association continues to afford exceptional opportunities for post graduate education to its members. The regularly bimonthly meetings of the Association are consistently in the first rank of scientific assemblies and more than formal thanks are due to the Program Committee and particularly its Chairman, Dr. Benedict Harris, for regularly securing speakers pre-eminent in scientific investigation and medical practice.

Dr. Francis G. Blake has seen to it that New Haven County stays abreast of the times in the treatment of pneumonia. Aside from clinics and lectures in his own bailiwick and reports spread upon the journals of the country, he has even ventured to Meriden and to Waterbury to



expound the gospel of sulfapyridine in pneumococcal infections.

Dr. Edward W. Foster of Meriden has recently been made director of the newly established Gynecological Service at the Meriden Hospital. Dr. Foster is also Chairman of the Obstetrical and Gynecological Section of the Connecticut State Medical Society and Chairman of the Knife & Stork Club.

Waterbury physicians continue to accomplish a splendid job in educating the public in matters pertaining to health. A recent public forum conducted by the Waterbury Medical Association was addressed by Dr. Charles W. Clarke, Executive Director of the American Social Hygiene Association in New York City, on the subject, "We Can Control Syphilis." Drs. Andrew C. Swenson and Edward J. Godfrey of Waterbury discussed the paper. Under the auspices of the Waterbury Mental Hygiene Society a panel discussion open to the public on "The Beginnings of Juvenile Delinquency" was participated in by George R. H. Nicholson, Headmaster of Kingswood School, West Hartford; Stanley P. Mead, Member of Conn. Public Welfare Council; Robert Heininger, Director of Union for Home Work, Hartford; Harold Strong, Director of Junior Republic, Litchfield; Dr. Arthur H. Jackson, Psychiatrist, Waterbury; Mrs. Frances L. Roth, Attorney, New Haven.

The Waterbury Medical Society conducted another public forum recently on the procacious subject "A National Health Program." Naturally our own Creighton Barker was the spell binder of the occasion.

Dr. Frank H. Lahey, Director of the famed Lahey Clinic, addressed the regular monthly meeting of the Waterbury Medical Association in March on the subject "Newer Surgical Entities of the Past Decade, Their Diagnosis and Management."

From the University comes announcement of the receipt of new grants in support of the Clinic of Child Development, School of Medicine. The General Education Board of the Rockefeller Foundation has made a grant-in-aid of \$85,000 which will be distributed over a period of five years and The Carnegie Corporation has appropriated the amount of \$10,000 per year for three years. Under the direction of Dr. Arnold Gesell the Clinic of Child Development is continuing its systematic studies of the behavior of infants.

A new program which these grants makes possible will give special attention to the medical aspects and clinical applications of research in child development.

The first number of *Psychosomatic Medicine*, a quarterly journal designed "to encourage and bring together studies which make a contribution to the understanding of the organism as a whole in somatic and psychic aspects," has recently been published. It is sponsored by the National Research Council's Committee on Problems of Neurotic Behavior, of which Professor Walter R. Miles is chairman, and is financed with the assistance of the Josiah Macy, Jr., Foundation. Professors Clark L. Hull and Grover F. Powers, and Dr. Flanders Dunbar, '30 M., are on the editorial board; Professor John F. Fulton and Dr. Ephraim Shorr, '18, '22M., are members of the advisory board; Dr. Dunbar is also managing editor.

Dr. Paul W. Preu, Assistant Professor of Psychiatry and Mental Hygiene, has published an *Outline of Psychiatric Case Study* through Paul B. Hoeber, Inc., medical book department of Harper Brothers, New York, (1939, 140 pp.)

Dr. Logan Clendening, professor of clinical medicine at the University of Kansas and author of "Behind the Doctor," "The Care and Feeding of Adults," and other books, recently spoke on "Medicine in Paris at the Time of Oliver Wendell Holmes' Visit," in the auditorium of Sterling Hall of Medicine.

The Beaumont lectureship on the History of Medicine was founded in 1930 by bequest from Dr. William H. Carmalt of New Haven and this year's lecture described the center of medical training in the 1830's. Dr. Ernest Caulfield of Hartford, president of the Beaumont Medical Club introduced Dr. Clendening.

On April 18 the sixth Harry Burr Ferris lecture was given by Professor Charles H. Danforth of Stanford University on "Human Hair."

Also in April the Yale Medical Society was addressed by Dr. F. G. Young of the National Institute for Medical Research, London, on "The Influence of Diabetogenic Pituitary Extract on Normal Animals."

On May 10 Dr. Thomas Francis, Jr., Professor of Bacteriology, New York University College of Medicine, spoke on "Studies of Immunity to the Virus of Epidemic Influenza" before the Society. Dr. Francis' paper on a related subject



before the New Haven Medical Association earlier in the season was one of those which contributed significantly to the high standard of the Association's scientific program.

During the months of February, March and April the New Haven Medical Association presented a series of radio broadcasts for public education in health over station WICC under the title of "Education in Health." The series of health talks was given under the direction of the Committee on Radio Broadcasts of the New Haven Medical Society consisting of Dr. Theodore S. Evans, Dr. Joseph I. Linde, and Dr. Barnett Greenhouse, chairman. The lists of speakers and subjects presented follows:—

Dr. Barnett Greenhouse — Health for Health's Sake

Dr. Charles T. Flynn — The Common Cold

Dr. Creighton Barker — National Health Program

Dr. Ralph E. McDonnell — Cosmetics and Common Sense

Dr. Maxwell Lear — Acute Appendicitis

Dr. Benedick R. Harris — Hearts Good and Bad

Dr. John P. Peters — Diabetes

Dr. Anthony J. Mendillo — Gall Bladder Disease

Dr. Frederick A. Wies — Eyes

Dr. Bernhard A. Rogowski — Problems of Nervous & Mental Disease

Dr. Clarence L. Robbins — Kidney Disease

Dr. Clement F. Batelli — Round table discussion on Early Diagnosis of Tuberculosis

These radio broadcasts were initiated last year by the Nutrition Committee of the Council of Social Agencies and presented under the direction of Dr. Greenhouse with the supervision of the New Haven Medical Society. Because of the medical nature of the programs the medical society, at the invitation of the Nutrition Committee, this year took over and presented the series of broadcasts now completed.

The public response to these presentations was sufficiently favorable to warrant another series next year.

John F. Fulton, M.D., Yale University School

of Medicine, read a paper on "Medical Academies: Past and Future" at the convocation called to dedicate the new home of the Rochester Academy of Medicine, Rochester, N. Y., on January 11, 1939. This paper appears printed in full in New York State Journal of Medicine, issue of May 15, 1939.

Edwin F. Gildea, M.D. and Paul W. Preu, M.D., both of Yale University School of Medicine, read papers on "Relationship of Vitamin Deficiencies to Neurological and Psychiatric Problems" and "Symptomatic Psychoses with Special Reference to Bromide Intoxications," respectively, at an open meeting of the Rhode Island Society for Neurology and Psychiatry on April 10, 1939.

### New London

Doctor Maurice Roberts Moore of Norwich, pathologist at the W. W. Backus Hospital, Norwich State Hospital and the Lawrence and Memorial Associated Hospitals of New London for the past nine years, is the new superintendent of the Backus Hospital. Dr. Moore who will assume his new position about the middle of June will resign as pathologist at the Lawrence and Memorial Hospitals and at the Norwich State Hospital. A native of Ontario and a graduate of Albert College and of Queens University, Dr. Moore has been prominent in the work of the Connecticut Association of Public Health and Clinical Laboratories. He is a member of the Tumor Committee of the State Medical Society and one of the news editors of the Society's Journal.

Doctor and Mrs. H. A. Bergendahl of Taftville announce the birth of a son born on April 7. From the same town comes the news of the arrival of a daughter to Doctor and Mrs. H. A. Archambault on May 5.



**The Program Committee of the State Society is to be congratulated on the excellent arrangement of the meetings at New Haven. The registration testified to its popularity.**

## Letters to the Editor

### QUO VADEMUS: AN OPEN LETTER

By Anonymous

Frankly the purpose of this communication is to provoke expression and discussion which is in order in any democratic organization. While organized medicine at present is under attack from many sides it must be sure of the wholehearted loyalty and support of its constituent membership. Any cause of discontent should be subjected to close scrutiny.

The great majority of physicians in this country are general practitioners. Out of the total of 140,000 physicians in the country only 14,000 are Diplomates of Specialty Boards. Even doubling this latter figure does not affect the validity of the foregoing statement. As a rule the general practitioners are too preoccupied in their daily tasks of looking after their patients to be able or willing to attend meetings of councils and committees in distant cities. As a result the direction of their organizations — the A.M.A. and its component State Societies — has gravitated to specialists, university teachers and others who are not obliged to carry the burdens of an urgent practice.

The views expressed by this group and the actions resulting therefrom are, in spite of every effort to be coldly objective and dispassionate, necessarily colored by their own status and sphere of activity. It is for this reason that the general practitioner — the man in the field — often finds himself dissatisfied with the action that is taken in his name by representatives who are not entirely conversant with his daily problems and desires. This accounts for the many autonomous local societies that have grown up like mushrooms in every larger city. It is only in these less formal and more cohesive units that the little man can be articulate and can be heard. And in these groups closer to the ground is welling up a grievance which should be aired in the open or it will lend fuel to the present opponents of organized medicine.

Time was when the ambitious general practitioner could by application, zeal and knowledge born of experience and continued study develop

special skills. This might have been in a field of general surgery, obstetrics, pathology or any other branch of medical practice. He became recognized by his colleagues as a specialist and consultant not because he limited his field but because he acquired special skill and knowledge to an extraordinary degree. He was under no constraint to account to anybody for the age, sex or previous condition of servitude of his patients. In fact it was felt that repeated contact with patients of all types and complaints that he judged himself competent to treat, helped to make him a better physician. It was from such men that we got an Oliver Wendell Holmes, Abraham Jacobi, Bull, Janeway and more recently the late William H. Park, whose first interest lay in otolaryngology and who wound up a renowned bacteriologist, or Emanuel Libman who began with an interest in children's diseases and is now an eminent cardiologist.

It is safe to say that many of the "official" specialists now had found and developed their metier while engaged in diversified practice. Having attained the heights themselves, they have seen fit to erect a fence which those that came after them must hurdle to reach that same degree of eminence that they had attained. In effect the active general practitioner because of this rigid fence is or will soon be entirely precluded from climbing higher in his chosen profession. Strange that we should find at this late date and in this liberal art a survival of the old craft-guild idea!

Sir Thomas Lewis has recently been quoted as using the phrase "disruption of medicine" in referring to the breaking off of the basic sciences such as pathology and physiology from the Medical Sciences. He might well have carried the idea further in applying it to Clinical Medicine which has become so fragmented that one specialty is coming to have only a nodding acquaintance with its fellows. It is considered irregular and 'infra-gid' for an obstetrician to look at tonsillitis or scabies.

A bitter controversy is raging now as to whether a pathologist may not do roentgenology. The issue is not whether he may not be as competent in both branches as any of his colleagues but whether this mild form of 'laissez-faire' would not interfere with the strict classification into specialists that is so highly prized by the powers that be.



The Specialty Boards originally were autonomous bodies without official standing or influence other than moral. They grew out of special scientific discussion groups — welcoming all who had anything of interest to offer. However, since in effect being taken over and sponsored by the Council on Medical Education and Hospitals of the A.M.A. they have by virtue of this fact become implemented with prestige and power. They can force changes in hospitals staffs and can affect the standing of an individual practitioner by a nod of approval or disapproval, and this power is becoming more manifest. Since the Council and all of the Boards consist, in the main of eminent specialists in their own field, the general practitioner finds himself subject to pressures in which he has had little part in the creating but to which he is subjected.

There can be no objection to certification consequent to oral or written examination to determine proficiency. But to limit the Diplomate's activity in his practice thereafter and to disqualify that large mass of physicians who by predilection or circumstance do not narrowly limit their practice — to keep from them the stamp of specialist purely on this score is a gratuitous function unsupported by any mandate from the main body of members — the general practitioner — and inconsistent with the license granted him by law to "practice medicine and surgery." The Council of Medical Education at the direction of the House of Delegates of the A.M.A. was granted the power to draw up qualifications, etc., for Specialty Boards. This was done very casually and with very little communion with the membership at large who woke up to a 'fait accompli'. To quote a specialist who stands high in this select circle of Examining Board and Editorial Board, "Any man is a specialist in anything which he can do unusually well." Another man equally eminent has said, "Men should be certified to practice anything for which they are properly qualified whether or not they limit their practice to that field and whether or not they have spent a given amount of time" (in preparation).

The anonymity of this letter is dictated by a desire to focus attention entirely on the subject matter and its merits, rather than on the identity of the writer.

**State of Connecticut  
DEPARTMENT OF HEALTH  
Hartford**

April 5, 1939

Editor,  
Journal of the Conn. State Medical Society,  
Hartford, Conn.

My dear Sir:

Here is something on "Sulfapyridine in Pneumonia" in case you want to use it in the Journal. It appeared to me that the opinion of the advisory committee on pneumonia control of the New York State Department of Health might be worth sending out to our own physicians.

Sincerely yours,  
Millard Knowlton, *Director*

**CHEMOTHERAPY IN PNEUMONIA**

Because of the encouraging reports of the use of sulfapyridine in the treatment of pneumonia, the Advisory Committee on Pneumonia Control of the New York State Department of Health met in a special session on February 17, 1939, and, after considering available data concerning the toxicity of this drug and the evidence as to its efficacy in the treatment of pneumonia, adopted the following resolution:

*"Be It Resolved That,*

"The Advisory Committee on Pneumonia Control to the New York State Department of Health, after weighing the available evidence, is of the opinion that sulfapyridine has a beneficial effect in the treatment of some patients ill with pneumococcal pneumonia.

"It is further the opinion of this Committee that the efficacy of antipneumococcus horse and rabbit sera for the treatment of certain types of pneumococcal pneumonia has been established. The evidence does not justify the substitution of sulfapyridine for serum therapy in all patients with pneumococcal pneumonia. Further investigations are necessary before it will be possible to state which patients should be treated with serum and which with sulfapyridine. Laboratory studies, including sputum typing and blood culture, are necessary for rational therapy and for the determination of the efficacy of any form of treatment.

"It is further the opinion of this Committee that sulfapyridine may be administered under competent supervision with reasonable safety in spite of the frequent evidence of toxicity.

"It is further the opinion of this Committee that the hazards incident to the administration of this drug can be lessened by careful clinical observations and by laboratory examinations which give warning of the more dangerous toxic effects which occasionally occur.

It is therefore the opinion of this Committee that, with the restrictions and precautions above mentioned, sulfapyridine should be released for use by physicians or on physicians' prescriptions."

*Bull. N.Y. State Dept. Health*



## UNION MEDICALE BALKANIQUE

22, Peyikhane caddesi,  
Istanbul

The Balkan Medical Union, in session at Istanbul, for the 5th Medical Week,

having taken into consideration the terrible sufferings which a total war will bring upon the civil population of open towns together with the total lack of any adequate means of protection.

and having discovered that even in its restricted form the project of "sanitary towns" has not yet been adopted, and that all efforts made to protect civilians against chemical warfare have till now remained as proposals only, and that even the protocol prohibiting the use of asphyxiating gas has not yet been ratified by all nations,

has therefore decided to address itself to doctors of every nation with an appeal to take active measures and to fulfill this professional and humanitarian duty of awakening and stirring public opinion.

The Balkan Medical Union believes that only enlightened international opinion can make plain the imminence of the danger and the proved uselessness, even for the victor, of these terrible atrocities, and can thus lead to effective action.

The immutable truth that

**hate breeds only hate, and atrocity breeds vengeance** must be impressed on everyone.

*Prof. Dr. Bensis, Dr. Scaramanga (Athenes),  
Dr. Zika Markovic, Prof. Dr. K. Sahovic,  
Dr. M. Simovic, (Beograd); Prof. Dr. Gheorghiu,  
Dr. Popescu Buzeu (Bucarest), Prof. Dr. Akil Muhtar Ozden, Prof. Sedat Tavat,  
Prof. Dr. A. Suheyl Unver (Istanbul).*

## The Doctor's Office

Lawrence P. Cogswell, M.D., announces the removal of his office from 179 Allyn Street to 50 Farmington Avenue, Hartford.

John F. Lynch, M.D., announces the opening of his office at 99 Pratt Street, Hartford, for the practice of General Surgery.

George C. Ludlow, M.D., announces the removal of his office from 858 Ocean Avenue, New London, to 8 Oenoke Avenue, New Canaan.

Oliver L. Stringfield, M.D., announces the removal of his office from 58 South Street to 1416 Bedford Street, Stamford.

Donald J. McCrann, M.D., announces the removal of his office from 7 South Main Street, West Hartford, to 50 Farmington Avenue, Hartford.

James L. Harrington, M.D., announces the removal of his office from 231 State Street, New London, to 27 Grove Street, Mystic.

The House of Delegates at its annual meeting recently accomplished much of importance to the Society. Read "Highlights" on page 303.

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# SPECIAL NOTICES

## PRELIMINARY PROGRAM

35TH

## ANNUAL MEETING

NATIONAL TUBERCULOSIS ASSOCIATION

BOSTON

MASSACHUSETTS

JUNE 26-29 1939

All Meetings will Be Held at the Hotel Statler  
Except the Clinics as Indicated

All Sessions are Open to Any Physician. No  
Registration Fee.

### Opening General Meeting

Monday, June 26, 8:15 P.M.

#### Address of the President

Chesley Bush, M.D., Livermore, Calif.

#### Report of the Managing Director

Kendall Emerson, M.D., New York City

#### Award of the Trudeau Medal

Charles J. Hatfield, M.D., Philadelphia, Pa.

#### Report of the Committee on Nominations

W. Atmar Smith, M.D., Charleston, S.C.

#### Joint Medical Session

Pathological and Clinical Sections

Tuesday, June 27, 9:30 A.M.

#### SYMPOSIUM: Genito-Urinary Tuberculosis

- (a) **Pathological Aspects of Genito-Urinary Tuberculosis**—

Oscar Auerbach, M.D., Sea View Hospital, New York City

- (b) **Modern Concepts of Urogenital Tuberculosis**—

Gilbert J. Thomas, M.D., University of Minnesota Medical School, Minneapolis, Minn.

#### SYMPOSIUM: Spinal Tuberculosis

- (a) **Pathological Aspects of Spinal Tuberculosis**—

T. A. Willis, M.D., Cleveland, Ohio

- (b) **Early Recognition and Treatment of Tuberculous Involvements of Vertebral Bodies**—

Mather Cleveland, M.D., New York City

#### SYMPOSIUM: Atelectasis

- (a) **Pathological Aspects of Atelectasis**—

Max Pinner, M.D., Montefiore Hospital, New York City

- (b) **Clinical Aspects of Atelectasis**—

Edward N. Packard, M.D., Saranac Lake, N.Y.

#### Pathological Section

Charles H. Boissevain, M.D., Colorado Springs, Colo.,  
*Chairman*

Arthur J. Vorwald, M.D., Saranac Lake, N.Y., *Vice-Chairman*

Tuesday, June 27, 2:00 P.M.

#### Correlation of X-ray Findings and the Pathology of the Cavity Walls—

Arthur J. Vorwald, M.D., Saranac Laboratory, Saranac Lake, N.Y.

#### Phases of Intoxication in Tuberculosis—

H. J. Corper, M.D. and Maurice L. Cohn, Ph.D., National Jewish Hospital, Denver, Colo.

#### Study of Localization and Type of Tuberculosis Lesions in Cattle—

E. M. Medlar, M.D., Metropolitan Life Insurance Company Sanatorium, Mount McGregor, N.Y.

#### The Growth of Tubercle Bacilli in the Tissues of Normal and of Allergic Guinea Pigs—

C. E. Woodruff, M.D. and Ruby G. Kelly, William H. Maybury Sanatorium, Northville, Mich.

Two other speakers to be announced.

### Clinical Section

D. O. N. Lindberg, M.D., Decatur, Ill., *Chairman*

John Alexander, M.D., Ann Arbor, Mich., *Vice-Chairman*

Wednesday, June 28, 9:30 A.M.

#### The Clinical Evaluation of Respiratory Function—

Walter K. Whitehead, M.D., and A. T. Miller, Jr., M.D., Detroit, Mich.

#### Pulmonary Function in Pulmonary Tuberculosis Under Various Forms of Collapse Therapy—

Andre Courmand, M.D., Bellevue Hospital, and Dickinson W. Richards, Jr., M.D., Associate Professor of Medicine, Columbia University, College of Physicians and Surgeons, New York City

#### Critical Survey of Extrapleural Pneumothorax Therapy—

Frank S. Dolley, M.D., Consulting Specialist, Olive View Sanatorium, Los Angeles, Calif.

#### Boeck's Sarcoid and Systemic Sarcoidosis—

David Reisner, M.D., Visiting Physician, Sea View Hospital, New York City

#### Clinical Studies of Asbestosis—

Moses J. Stone, M.D., Assistant Professor of Medicine, Boston University, School of Medicine, Boston, Mass.

### Joint Lay Sessions

Social Work and Administrative Sections

Tuesday, June 27, 9:30 A.M.

#### Interpreting Modern Methods of Tuberculosis Control to the Public

- (a) **From the official point of view—**

Henry F. Vaughan, Dr.P.H., Commissioner of Health Detroit, Mich.

- (b) **From the non-official point of view—**

Mrs. Katherine Z. W. Whipple, Secretary, Health Education Service, New York Tuberculosis and Health Association, New York City

#### Statutory Limitations on State and Federal Rehabilitation Service—

John A. Kratz, M.D., Chief, Vocational Rehabilitation Service, Office of Education, Washington, D. C.

Wednesday, June 28, 2:00 P.M.

**How Tuberculosis Associations May Use the Tuberculosis Specialist to Interest the General Practitioner in Tuberculosis —**

J. Emerson Dailey, M.D., Houston, Tex.

**The Training of Health Educators —**

C. E. Turner, Dr. P.H., Professor of Biology and Public Health, Massachusetts Institute of Technology, Cambridge, Mass.

**Regional Differences in Sanatorium Facilities from the Standpoints of Accommodations, Sources of Financial Support, and Operating Costs —**

Joseph W. Mountin, M.D., Senior Surgeon, United States Public Health Service, Washington, D. C.

**Joint Symposium**

Pathological, Clinical, Social Work, and Administrative Sections

Thursday, June 29, 9:30 A.M.

**Subject: Mass Tuberculin Testing and X-raying. A Review of Present Status**

**Tuberculin —**

Esmond R. Long, M.D., Director, Henry Phipps Institute, Philadelphia, Pa.

**X-ray Findings in Negative and Positive Reactors —**

Bruce H. Douglas, M.D., Tuberculosis Controller, Detroit Department of Health, Detroit, Mich.

**Epidemiological Considerations —**

James A. Doull, M.D., Professor of Hygiene and Public Health, School of Medicine, Western Reserve University, Cleveland, Ohio

**Discussion**

**Medical Clinics**

Joint Session of Pathological and Clinical Sections

Wednesday, June 28, 2:00 P.M.

**Committee on Clinics:**

Theodore L. Badger, M.D., Edward D. Churchill, M.D., Elliot C. Cutler, M.D., John A. Foley, M.D., Donald S. King, M.D., Frederick T. Lord, M.D., (Chairman), Harlan F. Newton, M.D., Richard H. Overholt, M.D., Sumner H. Remick, M.D.

(As indicated below, six medical clinics have been planned, all of them on Wednesday afternoon, June 28, from 2 to 4:30. In connection with clinics Number 2 and Number 4, special bus transportation will be provided at a nominal cost. The clinics are open to all physicians attending the meeting. Admission however will be by ticket only. Please write for reservations to Dr. Frederick T. Lord, 305 Beacon Street Boston, Mass., indicating which clinic you wish to attend and giving your preference for other clinics in case you cannot be admitted to your first choice. Clinics may be designated by number or by the hospital at which they are to be held. Early application for tickets is suggested, especially since the seating capacity of all the amphitheatres is limited. No charge is made for admission tickets.)

*Medical Clinic No. 1*

*Boston City Hospital*

*2:00-4:00 P.M.*

*Seating Capacity 265*

**Pneumococcus Pneumonia Associated with Pulmonary Tuberculosis —**

Maxwell Finland, M.D., Associate in Medicine, Harvard Medical School; Assistant Physician, Thorndike Memorial Laboratory, Boston City Hospital

**Acute and Chronic Mediastinitis—**

Chester S. Keefer, M.D., Associate Professor of Medicine, Harvard Medical School; Associate Physician, Thorndike Memorial Laboratory, Boston City Hospital

**Pulmonary Aspects of Cardiovascular Disease —**

Soma Weiss, M.D., Associate Professor of Medicine, Harvard Medical School; Associate Physician, Thorndike Memorial Laboratory, Boston City Hospital; Director, Second and Fourth Medical Services, Boston City Hospital

**X-ray and Clinical Manifestations of Boeck's Sarcoid**

Theodore L. Badger, M.D., Assistant in Medicine, Harvard Medical School; Chief of Thoracic Clinic, Boston City Hospital

**Parenchymal Lesion of the Lung in Lymphoma —**

Henry Jackson, Jr., M.D., Assistant Professor of Medicine, Harvard Medical School; Associate Physician, Thorndike Memorial Laboratory, Boston City Hospital

**Pulmonary Disorders in Diseases of the Blood —**

George R. Minot, M.D., Professor of Medicine, Harvard Medical School; Director, Thorndike Memorial Laboratory, Boston City Hospital

*Medical Clinic No. 2*

*Boston City Hospital, Sanatorium Division*

*2:00-4:00 P.M.*

*Seating Capacity 300*

**The Result of Pneumothorax at the Boston Sanatorium —**

John A. Foley, M.D., Clinical Professor of Medicine, Boston University; Chief of Staff, Boston City Hospital, Sanatorium Division

**Results of Surgical Treatment of Tuberculosis at the Boston Sanatorium —**

Horace Binney, M.D., Visiting Surgeon, Boston City Hospital, Sanatorium Division

**Tuberculous Tracheo-Bronchitis —**

Samuel Cline, M.D., Laryngologist, Boston City Hospital, Sanatorium Division

*Medical Clinic No. 3*

*Massachusetts General Hospital*

*2:00-4:00 P.M.*

*Seating Capacity 120*

**I. Bronchiectasis and Lung Abscess**

**11. Tumors of the Lung and Bronchi —**

Edward D. Churchill, M.D., John Homans Professor of Surgery, Harvard Medical School; Chief of West Surgical Service, Massachusetts General Hospital  
Donald S. King, M.D., Associate in Medicine, Harvard Medical School; Associate Physician, Massachusetts General Hospital; and associates

*Medical Clinic No. 4*

*Middlesex County Sanatorium*

*2:30-4:30 P.M.*

*Seating Capacity 300*

**Treatment of Spontaneous Pneumothorax —**

Frank P. Dawson, M.D., Assistant Physician, Middlesex County Sanatorium



**Bronchial Complications in Pulmonary Tuberculosis**

Lowery F. Davenport, M.D., Instructor in Medicine, Harvard Medical School; Internist, Middlesex County Sanatorium; Assistant in Medicine, Massachusetts General Hospital

Reuben Schulz, M.D., Instructor, Department of Pathology, Harvard Medical School; Instructor, Department of Hygiene, School of Public Health, Harvard Medical School; Pathologist, Middlesex County Sanatorium

**Management of Internal Pneumolysis Patients —**

Harlan F. Newton, M.D., Associate in Surgery, Harvard Medical School; Chief Surgeon, Middlesex County Sanatorium

**Treatment of Pulmonary Tuberculosis in the Adolescent —**

Henry D. Chadwick, M.D., Lecturer, School of Public Health, Harvard Medical School; Medical Director, Middlesex County Sanatorium  
Helen W. Evarts, M.D., Resident Physician, Middlesex County Sanatorium

*Medical Clinic No. 5*

*New England Deaconess Hospital  
2:00-4:00 P.M.*

*Seating Capacity 150*

**Some Experience in the Study of 350 Patients Suffering from Diabetes and Tuberculosis—**

Howard F. Root, M.D., Instructor in Medicine, Harvard Medical School; New England Deaconess Hospital and Joslin Clinic

**Combined Intrapleural and Extrapleural Pneumothorax—**

Julius G. Kelley, M.D., Superintendent, Barnstable County Sanatorium

**Extrapleural Pneumothorax—**

Richard H. Overholt, M.D., New England Deaconess Hospital

**Extrapleural Oleothorax—**

N. R. Pillsbury, M.D., Superintendent, Norfolk County Hospital

**Lobectomy and Pneumonectomy in Tuberculous Subjects—**

Garnet P. Smith, M.D., Superintendent, Bristol County Hospital

**Carcinoma of the Lung —**

Olin S. Pettingill, M.D., Superintendent, Essex County Sanatorium

**Do Results Justify Bilateral Thoracoplasty? —**

E. K. Jenkins, M.D., Norfolk County Hospital

**Thoracoplasty without Deformity —**

W. R. Rumel, M.D., New England Deaconess Hospital

*Medical Clinic No. 6*

*Peter Bent Brigham Hospital  
2:00-4:00 P.M.*

*Seating Capacity 238*

**Actinomycosis of the Lung and Pleura —**

Elliot C. Cutler, M.D., Moseley Professor of Surgery, Harvard Medical School; Surgeon-in-Chief, Peter Bent Brigham Hospital

Robert E. Gross, M.D., Instructor in Surgery, Harvard Medical School; Resident Surgeon, Peter Bent Brigham Hospital

**Tuberculosis in a Children's Hospital: A Fifteen-Year Survey —**

Clement A. Smith, M.D., Instructor in Pediatrics, Harvard Medical School; Associate Physician, Children's Hospital

**Cardiac Pseudo-Tuberculosis —**

Merrill C. Sosman, M.D., Assistant Professor of Roentgenology, Harvard Medical School; Roentgenologist, Peter Bent Brigham Hospital

**Tuberculosis in the Students of the Harvard Medical School —**

Roy M. Seideman, M.D., Commonwealth Fund, Tuberculosis Division, Massachusetts State Department of Health

**Experience with Extrapleural Pneumothorax —**

Harlan F. Newton, M.D., Associate in Surgery, Harvard Medical School; Senior Associate in Surgery Peter Bent Brigham Hospital

John E. Dunphy, M.D., Arthur Tracy Cabot Fellow, Harvard Medical School; Junior Associate in Surgery, Peter Bent Brigham Hospital

**Thirty-three years' Experience with the Treatment of Pulmonary Tuberculosis by the Group System in an Outdoor Department of a General Hospital —**

Nathaniel K. Wood, Associate in Medicine, Peter Bent Brigham Hospital

**AMERICAN CONGRESS OF PHYSICAL THERAPY**

The 18th annual scientific and clinical session of the American Congress of Physical Therapy will be held September 5, 6, 7, 8, 1939 at the Hotel Pennsylvania, New York City. Preceding these sessions the Congress will conduct an intensive instruction seminar in physical therapy for physicians and technicians — August 30, 31, September 1 and 2.

Physicians are urged to plan their vacation for these periods and bring their families to New York for the World's Fair. Ample time has been provided for during the convention to visit the fair and to enjoy the various activities of America's metropolis.

While the convention proper will have numerous special program features of scientific interest, the added attraction of the World's Fair should make it extremely worth while for every physician to come to New York and spend a most profitable vacation.

The instruction seminar should prove of unusual interest to physicians and technicians. The clinics which comprise half of the schedule make this course outstanding for its practical value. As in the past outstanding clinicians and teachers will participate. Registration is limited to 100 and is by application only. For information concerning seminar and preliminary program of convention proper, address American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

# PRELIMINARY PROGRAM OF SECTION ON MEDICINE, AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

CLEVELAND, OHIO  
SEPTEMBER 11-15, 1939

## PART 1—MORNING SESSIONS—9:00-11:30 A.M.

### MONDAY

(Five speakers, 10 minutes each and no discussion. Two speakers, 20 minutes each and 5 minutes discussion)

1. *The Thyroid and Pregnancy*  
*Speaker:* L. M. Randall, M.D., Rochester, Minnesota;  
Division of Obstetrics and Gynecology, Mayo Clinic
2. *Management of the More Common Heart Lesions During Pregnancy*  
*Speaker:* Julius Jensen, M.D., St. Louis, Missouri,  
Assistant Professor of Medicine, Washington University School of Medicine
3. *Treatment of Diabetes in the Pregnant Woman*  
*Speaker:* Henry J. John, M.D., Cleveland, Ohio
4. *Management of Tuberculosis Complicated by Pregnancy*  
*Speaker:* Edwin M. Jameson, M.D., Saranac Lake, New York;  
Attending Surgeon, General Hospital of Saranac Lake and Reception Hospital
5. *Nutritional Factors in Pregnancy*  
*Speaker:* Icie Macy Hoobler, Ph. D., Detroit, Michigan;  
Director of Research, Children's Fund of Michigan
6. *The Surgical Abdomen Complicated by Pregnancy*  
*Speaker:* Louis E. Phaneuf, M.D., Boston, Massachusetts;  
Professor of Gynecology, Tufts College Medical School  
*Discussant:* W.D. Fullerton, M.D., Cleveland, Ohio;  
Associate Gynecologist, Lakeside Hospital
7. *The Treatment of Abortions*  
*Speaker:* David S. Hillis, M.D., Chicago, Illinois;  
Associate Professor of Obstetrics, Northwestern University Medical School  
*Discussant:* Jalmar H. Simons, M.D., Minneapolis, Minnesota;  
Assistant Clinical Professor of Gynecology and Obstetrics, University of Minnesota;  
Chief of Obstetrics and Gynecology, Minneapolis General Hospital

### TUESDAY

(Four speakers, 20 minutes each; and four discussants, 5 minutes each)

1. *The Newer Conception of Ovarian Neoplasm*  
*Speaker:* Howard C. Taylor, Jr., M.D., New York City;  
Associate Professor of Gynecology and Obstetrics, New York University; Associate Surgeon, Memorial Hospital for the Treatment of Cancer and Allied Diseases; Gynecologist, Roosevelt Hospital  
*Discussant:* John L. McKelvey, M.D., Minneapolis, Minnesota;  
Professor of Obstetrics and Gynecology, University of Minnesota
2. *Special Features in the Operative Management of Surgically Difficult Malignant Growths and Kindred Lesions of the Pelvic Viscera*  
*Speaker:* Arthur H. Curtis, M.D., Chicago, Illinois;  
Professor of Obstetrics and Gynecology, Northwestern University Medical School

*Discussant:* Fred J. Taussig, M.D., St. Louis, Missouri  
Clinical Professor of Obstetrics and Gynecology, Washington University School of Medicine

3. *The Diagnosis and Treatment of Pelvic Endometriosis*  
*Speaker:* Franklin L. Payne, M.D., Philadelphia, Pennsylvania;  
Associate Professor of Obstetrics and Gynecology, University of Pennsylvania Medical School; Assistant Gynecologist, Hospital of the University of Pennsylvania; Obstetrician and Gynecologist, Pennsylvania Hospital; Gynecologist, Chestnut Hill Hospital

*Discussant:* Jean P. Pratt, M.D., Detroit, Michigan;  
Chief, Obstetrics and Gynecology, Henry Ford Hospital

4. *The Diagnosis and Treatment of Ectopic Pregnancy*

*Speaker:* John Rock, M.D., Boston, Massachusetts;  
Assistant in Gynecology, Harvard Medical School; Research Fellow, Boston Lying-in Hospital; Assistant Obstetrician, Massachusetts General Hospital  
Assistant Visiting Surgeon, Free Hospital for Women

*Discussant:* Harvey Matthews, M.D., Brooklyn, New York;  
Clinical Professor of Obstetrics and Gynecology, Long Island College of Medicine; Attending Gynecologist and Obstetrician, Long Island College and Methodist Episcopal Hospital

### WEDNESDAY

1. *Reduction of the Operative Incidence in Obstetrics*

*Speaker:* S. A. Cosgrove, M.D., Jersey City, New Jersey;  
Medical Director, Margaret Hague Maternity Hospital; Attending Obstetrician, Jersey City Medical Center

*Discussant:* A. C. Beck, M.D., Brooklyn, New York;  
Professor of Obstetrics and Gynecology, Long Island College of Medicine

2. *Practical Consideration of Labor Complicated by a Contracted Pelvis*

*Speaker:* John Harris, M.D., Madison, Wisconsin;  
Professor of Obstetrics and Gynecology, University of Wisconsin Medical School

*Discussant:* Thaddeus L. Montgomery, M.D., Philadelphia, Pennsylvania;  
Associate Professor of Obstetrics, Jefferson Medical College; Assistant Obstetrician, Jefferson Hospital; Gynecologist, Henry Phipps Institute

3. *Dystocia due to the Cervix and Soft Parts*

*Speaker:* W. C. Danforth, M.D., Evanston, Illinois;  
Associate Professor of Obstetrics and Gynecology, Northwestern University Medical School; Chief, Department of Gynecology and Obstetrics, Evanston Hospital; Member, Consulting Staff of Chicago Maternity Center

*Discussant:* George Kamperman, M.D., Detroit, Michigan;  
Attending Obstetrician and Gynecologist, Harper Hospital

4. *The Pathology and Treatment of the Retained Placenta*

*Speaker:* E. A. Schumann, M.D., Philadelphia, Pennsylvania;  
Professor of Obstetrics, University of Pennsylvania Medical School; Surgeon-in-Chief, Kensington Hospital for Women

*Discussant:* Albert Mathieu, M.D., Portland, Oregon;  
Assistant Clinical Professor of Obstetrics and Gynecology



cology, Oregon University Medical School; Attending Gynecologist, Multanomal County Hospital; Staff and Consulting Obstetrician, St. Vincent's Hospital

#### THURSDAY

##### 1. *Treatment of Endocrine Disturbances in the Adolescent Female*

*Speaker:* Emil Novak, M.D., Baltimore, Maryland; Associate in Clinical Gynecology, John Hopkins University School of Medicine; Visiting Gynecologist, St. Agnes and Bon Secour Hospital and Hospital for the Women of Maryland

*Discussant:* B. M. Anspach, Philadelphia, Pennsylvania; Professor of Gynecology, Jefferson Medical College; Attending Gynecologist, Jefferson Hospital; Consulting Gynecologist, Bryn Mawr Hospital, Bryn Mawr

##### 2. *The Treatment of Menopausal Disturbances*

*Speaker:* August A. Werner, M.D., St. Louis, Missouri; Associate Professor of Internal Medicine, St. Louis University School of Medicine

*Discussant:* E. L. Sevringhaus, M.D., Madison Wisconsin; Associate Professor of Medicine, University of Wisconsin School of Medicine

##### 3. *Practical Endocrine Therapy in Obstetrics and Gynecology*

*Speaker:* Edward Allen, M.D., Chicago, Illinois; Assistant Professor of Obstetrics and Gynecology, Rush Medical School, University of Chicago

*Discussant:* E. C. Hamblen, M.D., Durham, North Carolina; Associate Professor of Obstetrics and Gynecology, Duke University Medical School; Associate Gynecologist and Director, Sex-Endocrine Clinic, Duke Hospital

##### 4. *Sterility in the Female*

*Speaker:* S. R. Meaker, M.D., Boston, Massachusetts; Professor of Gynecology, Boston University School of Medicine; Gynecologist, Massachusetts Memorial Hospital

*Discussant:* M. E. Davis, M.D., Chicago, Illinois; Associate Professor of Obstetrics and Gynecology The School of Medicine of the Division of Biological Sciences, University of Chicago; Attending Obstetrician and Gynecologist, Chicago Lying-in Hospital and University Clinics

#### FRIDAY

##### 1. *Sulfanilamide in Obstetrics and Gynecology*

*Speaker:* Perrin Long, M.D., Baltimore, Maryland; Associate Professor of Medicine, University of Maryland School of Medicine and College of Physicians and Surgeons

*Discussant:* E. M. K. Geiling, M.D., Chicago, Illinois; Professor of Pharmacology, Rush Medical College, University of Chicago

##### 2. *Pyelitis*

*Speaker:* Herbert F. Traut, M.D., New York City; Associate Professor of Obstetrics and Gynecology, Cornell University Medical College

*Discussant:* J. Mason Hundley, Jr., M.D., Baltimore, Maryland; Professor of Gynecology, University of Maryland School of Medicine and College of Physicians and Surgeons

##### 3. *The Treatment of Chronic Pelvic Infections*

*Speaker:* Charles C. Norris, M.D., Philadelphia, Pennsylvania; Professor of Obstetrics and Gynecology, Director of Department, University of Pennsylvania School of Medicine; Gynecologist and Obstetrician, Hospital of the University of Pennsylvania; Associate Obstetrician and Gynecologist-in-Chief, Pennsylvania Hospital

*Discussant:* J. P. Greenhill, M.D., Chicago, Illinois; Professor of Gynecology, Loyola and Cook County Graduate School; Attending Gynecologist, Cook County Hospital

##### 4. *Immediate and Remote Complications of Labor*

*Speaker:* Frank W. Lynch, M.D., San Francisco, California; Professor of Obstetrics and Gynecology University of California Medical School; Obstetrician and Gynecologist, University of California Hospital

*Discussant:* G. D. Royston, M.D., St. Louis, Missouri; Professor of Clinical Obstetrics and Gynecology, Washington University School of Medicine; Associate Obstetrician and Gynecologist, Barnes and St. Louis Maternity Hospitals

#### PART II—ROUND TABLES

(Running concurrently each day from 12:15 P.M. to 1:15 P.M.)

##### The Toxemias of Pregnancy

*Monday,* F. S. Kellogg, M.D., Boston, Massachusetts; Assistant Professor of Obstetrics, Harvard University Medical School

*Tuesday,* Herman Johnson, M.D., Houston, Texas; Attending Obstetrician, Baptist, Jefferson Davis, St. Joseph's and Hermann Hospitals

*Wednesday,* W. J. Dieckmann, M.D., Chicago, Illinois; Associate Professor of Obstetrics and Gynecology; The School of Medicine of the Division of the Biological Sciences, University of Chicago

*Thursday,* E. L. King, M.D., New Orleans, Louisiana; Professor of Obstetrics, Tulane University School of Medicine; Visiting Surgeon, Department of Obstetrics, State of Louisiana Charity Hospital

*Friday,* R. A. Ross, M.D., Durham, North Carolina; Assistant Professor, Obstetrics and Gynecology, Duke University School of Medicine; Obstetrician, Watts Hospital

##### Genital Infections

*Monday,* B. P. Watson, M.D., New York City; Professor of Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons

*Tuesday,* O. H. Schwarz, M.D., St. Louis, Missouri; Professor of Obstetrics and Gynecology, Washington University School of Medicine

*Wednesday,* J. R. Goodall, M.D., Montreal, Quebec; Clinical Professor of Obstetrics and Gynecology, McGill University Faculty of Medicine

*Thursday,* John Fraser, M.D., Montreal, Quebec; Professor of Obstetrics and Gynecology, McGill University Faculty of Medicine

*Friday,* Bayard Carter, M.D., Durham, North Carolina; Professor of Obstetrics and Gynecology, Duke University School of Medicine



**Obstetric and Gynecologic Hemorrhages**

*Monday*, George Gray Ward, M.D., New York City; Clinical Professor of Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons; Professor of Obstetrics and Gynecology Emeritus, Cornell University Medical College

*Tuesday*, Wm. P. Healy, M.D., New York City; Gynecologist, Memorial Hospital

*Wednesday*, J. C. Litzenberg, M.D., Minneapolis, Minnesota; Professor and Chief, Obstetrics and Gynecology, University of Minnesota Medical School

*Thursday*, Norris W. Vaux, M. D., Philadelphia, Pennsylvania; Professor of Obstetrics, Jefferson Medical College

*Friday*, W. R. Cooke, M.D., Galveston, Texas; Professor of Obstetrics and Gynecology, University of Texas School of Medicine

**The Fetus and the Newborn**

*Monday*, LeRoy A. Calkins, M.D., Kansas City, Missouri; Professor of Obstetrics and Gynecology, University of Kansas School of Medicine

*Tuesday*, W. A. Scott, M.D., Toronto, Ontario; Professor of Obstetrics and Gynecology, University of Toronto Faculty of Medicine

*Wednesday*, Stewart H. Clifford, M.D., Boston, Massachusetts

*Thursday*, Herbert C. Miller, Jr., M.D., New Haven, Connecticut

*Friday*, Edith L. Potter, M.D., Chicago, Illinois; Instructor and Pathologist, Department of Obstetrics and Gynecology, University of Chicago

**Forceps, Occiput-Posteriors, and Breech Presentation**

*Monday*, Arthur H. Bill, M.D., Cleveland, Ohio; Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine

*Tuesday*, Paul Titus, M.D., Pittsburgh, Pennsylvania

*Wednesday*, W. E. Caldwell, M.D., New York City; Professor of Clinical Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons

*Thursday*, M. Pierce Rucker, M.D., Richmond, Virginia

*Friday*, J. B. Jacobs, M.D., Washington, D.C.; Associate Professor of Obstetrics, Georgetown University School of Medicine

**Anesthesia, Analgesia and Amnesia in Labor**

*Monday*, N. J. Eastman, M.D., Baltimore, Maryland; Professor of Obstetrics, Johns Hopkins University School of Medicine

*Tuesday*, R. A. Bartholomew, M.D., Atlanta, Georgia; Professor of Clinical Obstetrics, Emory University School of Medicine

*Wednesday*, W. T. Pride, M.D., Memphis, Tennessee; Professor of Obstetrics, University of Tennessee College of Medicine

*Thursday*, Howard F. Kane, M.D., Washington, D.C.; Professor of Obstetrics and Gynecology, George Washington University School of Medicine

*Friday*, Clifford B. Lull, M.D., Philadelphia, Pennsylvania; Assistant Professor of Obstetrics, Jefferson Medical College

**MEMBERSHIP**

Membership fee is \$5.00, which includes a year's member-

ship in The American Committee on Maternal Welfare and registration in The American Congress on Obstetrics and Gynecology, Cleveland, Ohio, September 11-15, 1939.

Headquarters Office: The Annex, 650 Rush Street, Chicago

Make checks payable to R. W. Holmes, Treasurer  
Chairman State Committee:

Dr. Joseph H. Howard, Bridgeport.

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**MICHAEL REESE HOSPITAL  
CARDIOVASCULAR DEPARTMENT**

Offers a Full-time Intensive Course  
in

**ELECTROCARDIOGRAPHY**

Two Weeks—August 21—September 2, 1939

by Dr. Louis N. Katz

Director of Cardiovascular Research

This is an intensive course offered to the general practitioner. There will be practice on several electrocardiographic machines and discussion of the principles of their construction and use. There will be sessions on interpretations of electrocardiograms illustrated by lantern slides and practice by the student with unknown records. Routine records taken during the time of the course will be discussed. Emphasis will be placed on chest leads and on the importance of the electrocardiogram in coronary sclerosis and thrombosis. The mechanism and interpretation of heart irregularities will be developed.

As group and individual instruction will be given, the course is open to both the beginning and advanced student in Electrocardiography. It is planned to individualize the course so that at the end of the period each student will be capable of taking and properly interpreting routine electrocardiograms. In order to accomplish this purpose the class will be limited in number. It is imperative, therefore, that reservations be made early.

For further information address

**MICHAEL REESE HOSPITAL  
CARDIOVASCULAR DEPARTMENT  
29th and Ellis Ave.  
Chicago, Illinois**

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**AMERICAN BOARD OF INTERNAL  
MEDICINE, INC.**

Written examinations for certification by the American Board of Internal Medicine will be held in various sections of the United States on the third Monday in October and the third Monday in February.

Formal application must be received by the Secretary before August 20, 1939 for the October 16, 1939 examination, and on or before January 1 for the February 19, 1940 examination.

Application forms may be obtained from Dr. William S. Middleton, Secretary-Treasurer, 1301 University Avenue, Madison, Wisconsin, U.S.A.

## • OBITUARIES •

LOREN RAY WEIR, M.D.

1884-1938

Dr. Loren Ray Weir was born in Burnside, Illinois, on March 7, 1884. He received his earlier education at the Galesburg Illinois High School. In 1911 he entered the Hahnemann Medical College of Kansas City, Missouri, from which he received his medical degree in 1915.

Following his graduation he did general practice in Lathrop, Missouri until 1918, at which time he received the appointment of First Lieutenant in the medical corps at Fort Riley, Kansas.

On November 13, 1919, he married Miss Mae Carter of Lathrop, Missouri, and following his marriage he went to the Ophthalmic Hospital in New York City to do post-graduate work. He remained there from September 1920 to July 1922. Upon completing his studies he received the degree of "Oculi et Auris Cherugis."

While at the Ophthalmic Hospital he met Dr. M. Barraquer of Barcelona, Spain, well renowned for the Barraquer technique for removal of cataract and it was here also that Dr. Weir saw Dr. Barraquer work. Dr. Weir became so absorbed in his work that in July 1922 he went to Barcelona and registered in Dr. M. Barraquer's Clinic and worked under his supervision until October 1922.

Following his return from Europe he settled in New Britain, Conn., for the practice of eye, ear, nose and throat, where he remained until his death.

He was a member of the Moila Temple of Mystic Shrine, the Hartford County Medical Association, the New Britain Medical Society and the New Britain General Hospital Staff.

Dr. Weir was a self made man. His profound judgment and sense of responsibility was displayed in every professional problem with which he was confronted. He is survived by his wife.

— Raoul J. Benoit, M.D.

## • Quarto Notes •

SURGICAL PATHOLOGY OF THE MOUTH AND JAWS

Arthur E. Hertzler, M.D.

248 pages

\$5.00

Philadelphia

Montreal

London

J. P. Lippincott Company

In the tenth and final volume of a series of monographs on surgical pathology, Hertzler presents the pathological conditions involving the mouth, jaws, and nasopharynx in his usual intriguing manner, his style makes the subject entertaining as well as informative, based as it is on a long and practical experience. As he states so typically in his preface: — "I have always found it impossible to write of things that I have not seen. Therefore many of the things described in other books, I have not mentioned because I have not seen them. I have travelled a long ways so that I conclude that what I have not seen must be rare and it is fair to hope that likely the majority of surgeons will live a lifetime without seeing them."

That this book is based on his rich experience is rather facetiously expressed by his pointed: — "I have always held the idea that one had no right to quote literature which he had not read in the original . . . I have adopted the more respected practice of having my secretary copy them out of the cumulative index. Therefore if the papers cited are not good, do not blame me, I have not read them."

The book is practical for the very reason that the subject material presented is stressed according to the frequency of incidence and its value greatly enhanced by the large number of excellent illustrations. (206). The inflammatory conditions, benign tumors, and malignant neoplasms are equally well covered.

The physical makeup is attractive. It is a text that can be recommended to the general surgeon, the dentist, and as a reference work for the general practitioner, and one might say almost secondarily to the pathologist.

P. G. Mc Lellan



CLINICAL GASTRO-ENTEROLOGY

by

Horace Wendell Soper, M.D. F.A.C.P.

314 pages

212 illustrations

\$6.00

St. Louis

C. V. Mosby Co.

1939

The book is written by a clinician of long years of experience in gastro-enterology. The type is good. There are very few typographical errors. The chapters are short. The illustrations deal mostly with x-ray films and are of average quality. An unusual feature to the reviewer is the wholesale condemnation of the use of pasteurized milk in the treatment of peptic ulcers for fear of bacterial infection from the milk. There is little new or unusual in the presentation.

J. A. Wentworth



## MATERIA MEDICA, TOXICOLOGY, AND PHARMACOGNOSY

by

William Mansfield, A.M., Phar. D., Dean and  
Professor of Materia Medica and Toxicology,  
Union University, Albany College of Pharmacy,  
Albany, N.Y.

707 pages      202 illustrations      \$6.75  
St. Louis      C. V. Mosby Co.,      1937

As the preface states, this is a text and reference book on the Therapeutics, Toxicology, Pharmacognosy and Posology of the official drugs of the United States Pharmacopeia XI, National Formulary VI.

It is written for physicians, pharmacists and students of medicine, pharmacy and nursing.

It is of handy size.

The greater part of the book deals with Materia Medica.

The information is arranged systematically.

It gives the essential facts which are expected in such a book and the numerous photographic illustrations are good.

The Section on Poisons comprises 124 pages. This is written in a very readable and practical way. The causes, types and conditions modifying poisons are considered. The symptomatology and the common treatment are given.

Under Posology the dosage of U.S.P. and N.F. drugs are listed, as well as drugs for which no dosage is given.

At the end of the book there is a helpful glossary of terms used.

The text covers a wide field of knowledge and still it contains much information of the subjects treated in simple form.

J. A. Wentworth



## INSOMNIA

### Its Causes and Treatment

by

John A. P. Millet, M.D.

187 pages      \$1.75  
Greenberg      New York      1938

This volume is the work of an eminent psychiatrist who has drawn upon his own professional experience and extensive reading for the ideas expressed. Its chapters are logically arranged and include, among others, chapters on the physiology of sleep, disturbances of sleep, causes of insomnia and the treatment of insomnia. It is designed

for the lay reader and especially for the sufferer from insomnia, to whom it will be reassuring. It consists of one hundred and eighty-seven pages of good print and is published by Greenberg of New York

H. A. Bancroft



## YOU CAN'T EAT THAT

by

Helen Morgan

New York

1939

Harcourt, Brace & Co.

Miss Morgan's book represents an attempt to explain in lay language the reason for and the technique of following allergic diets. Written in a characteristically feminine, enthusiastic style, it tends to overemphasize the scope of food allergy and perhaps to overemphasize the pleasures of dietary privations. The chapters on the cause of allergy are well written and describe in non-technical language the significance of several of the classical experiments and clinical observations leading to the opening of the field of clinical allergy. The work of Praussnitz and Kustner on passive transfer, the early observations of Sir Hyde Salter on the relation of asthma to animal danders, and in one family to hypersensitivity to milk, the complete study of Blackley on the relation of pollen to hay fever, and the experimental work of Richet and of Theobald Smith on the production of anaphylaxis are all clearly described. Wolff-Eissner's correct interpretation of this phenomenon and Von Pirquet's clinical observations on hypersensitivity in man are recounted, making a review of the fundamentals of allergy which could profitably be read by most medical men.

The chapter on diagnosis is a routine exposition of technique, which is not entirely accurate. The implication that scratch tests "went out of style" ten years ago is misleading. The remarks on the use of elimination diets as diagnostic rather than therapeutic procedures, however, are well chosen.

The main body of the volume deals with generalizations about the use of substitute foods and includes specific recipes demonstrating these rules. It contains a mass of factual material of infinite value: names of concerns from whom rare products may be obtained; lists of contents of various trade-marked preparations; and commercial uses for various animal and vegetable substances. After a careful study of this book an intelligent housewife should be able to prepare palatable meals even without such fundamentals as milk, wheat, or eggs. The book should greatly facilitate the physician's task in prescribing allergic diets.

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(SEE PAGE 2.)

## HUGE SYLPHILITIC ANEURYSM

(Continued from Page 277)

see what is happening." From a pin point opening there was a stream of blood spurting four to five feet out into the room. Then other small streams spurted. Large pressure pads were applied and one gr. of morphine was given hypodermically. The bleeding continued slowly for several hours but she became unconscious and exitus was peaceful after four hours without any especially distressing feature such as had been dreaded.

Autopsy was refused.

### Comment

This case has seemed worthy of record because of the size of the aneurysm, the lack of subjective symptoms, and the dramatic termination.

—☆☆—

## SURGICAL TREATMENT OF HYPERTENSION

(Continued from Page 269)

We have been encouraged by the improvement in the subjective symptoms associated with the disease. Headaches in particular have been relieved, nervousness has been diminished, a tendency to fatigue has been lessened and the feeling of well-being has been increased. We have observed the disappearance of papilledema, hemorrhage and exudate in eyegrounds and occasionally improvement in vision.

There has been a difference in the results in lowering the actual blood pressure in the above groups. Following all three operations there has been a definite lowering of blood pressure; but it would appear from our small experience that the patients who have been subjected to the operation of anterior root section maintained a lower blood pressure level for a longer period of time than those subjected to the other two operations. For instance, in this group there were 6 patients whose blood pressure at the end of 3 years had not reached the pre-operative level. In the supradiaphragmatic splanchnicotomies and the subdiaphragmatic splanchnicotomies, there has been a tendency for the blood pressure to return to the pre-operative level in a shorter period of time. Apart from the actual lowering of the blood pressure level, we are encouraged by the general improvement of these patients as we have emphasized above.

Supported by a grant from the John and Mary Markle Foundation.

## IT HAS STOOD THE TEST

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### YALE MEDICAL SCHOOL REQUIRES FUNDS FOR BUILDING.

Need for \$5,275,000 with which to expand the facilities of the Yale School of Medicine is pointed in a booklet just published, "Doctors for America." The booklet is published as part of a quiet move to increase the resources of the medical school, New Haven hospital and New Haven Dispensary.

These three institutions plan no extensive campaign for the needed funds, but propose, through the booklet, to bring the accomplishment and achievements of the medical school, along with its future objectives to the attention of those in a position to substantially contribute.

First among the buildings to be erected under the contemplated building program for which funds are needed is one to house a medical library, History of Medicine hall, lobby and catalogue section and an auditorium, all costing, including an endowment for maintenance, \$2,675,000. The building program also calls for construction of a residential quadrangle to house 200 students and to be built at an estimated cost of \$2,200,000. The university has already acquired the site for this structure.

The final part of the program calls for a 150 feet addition to the Cedar street side of the Sterling Hall of Medicine to add 32,000 square feet of floor space to relieve the congestion in several laboratories.

The medical school also requires gifts to its endowment fund.

Before broaching the needs of the three institutions, all closely interwoven through commonness of purpose, the booklet traces the part Yale has played in medicine from the days of Jared Elliot, Yale, 1706, and father of practicing medicine in Connecticut to date. It deals briefly with the founding of the medical school in 1810 and its subsequent growth up to 1914 when the modernization and expansion of the medical school was begun.

The growth and progress of the school from 1920 when it had total assets of \$2,500,000, including land, buildings and endowment to its present size and high ranking position among American medical schools is also recorded. Today the assets of the school are placed at \$11,500,000.

Replete with actual pictures of the work being done at the three institutions, the booklet des-

cribes their various and nearly innumerable present day activities and their importance in the general scheme of health.



### NEW HAVEN OPHTHALMOLOGICAL SOCIETY

Announcement is made of the formation of the New Haven Ophthalmological Society. The first meeting was held April 17, 1939. Dr. Eugene M. Blake is President and Dr. Frederick A. Wies, Secretary.



### PHYSICAL THERAPY SCHOOL RECEIVES JUNIOR COLLEGE CHARTER

The New Haven School of Physical Therapy founded in 1919 by Harry Eaton Stewart, M.D. has received its charter from the present Legislature, and with it the power to confer the degree of Associate in Science.

The School was incorporated as a non-profit Institution in 1936, under a Board of Trustees consisting of Dr. Wm. Gilbert Anderson; Dr. C. Seaver Smith; Dr. A. K. Boardman; Judge Pierpont Foster and Mr. H. C. Prescott. Some hundred physicians and four hundred technicians have been graduated by the School.

Last year, to fill a new and urgent need, a years course of training for high school graduates, was inaugurated and termed Medical Assistant. This course now becomes the Junior year and Physical Therapy the Senior year of the new College plan.

The School desires to serve the Profession of the State in every way possible. Medical assistants, and technicians in Physical Therapy, X-ray and Laboratory are available. Substitute or volunteer help may also be arranged for with the School. Address H. E. Stewart, M.D., President, 262 Bradley Street, New Haven, Conn.



History is being written in medicine right here in Connecticut today. The general assembly is considering several bills of importance to the medical profession.

## SYMPOSIUM ON CANCER OF PROSTATE

(Concluded from Page 296)

strong appeal to urological surgeons for total excision by the perineal route. Connecticut is slow to grasp this problem of malignancy. Cancer of the prostate is a curable disease.

Study of the case histories and development of the tables is hereby credited to Dr. John Gens.

### GENERAL DISCUSSION

Dr. Kendall requested that as the time was short the discussion be limited to questions.

Dr. Deming, when asked what his criterion was for a radical prostatectomy, replied: when the cancer is limited to the prostate or to the lower tip of the seminal vesicles not invading the trigone, the absence of metastatic lesions by X-ray, and the absence of perineal pain.

Drs. Margold and Bidgood, when asked if in their experience the impression had been that cases without demonstrable metastases soon developed them after transurethral resection, replied: It is not our impression that the transurethral operation spreads metastases. This treatment is purely a palliative procedure for the relief of retention, and in many instances when this procedure is used in a case of benign hypertrophy, it is followed by complications such as pyuria and infection, etc. It is not our belief that these complications ensue only after treatment for cancer, nor is the patient made more miserable nor does transurethral resection produce metastases. Dr. Bidgood said that it was the belief of some authorities that transurethral prostatectomy stirred up the cancer.

Dr. Oughterson said that the program had not yet been completed for the next meeting in New Britain in April. He then demonstrated a chart prepared by Dr. Watkins showing the distribution of cancer in men and women in Connecticut in relation to its anatomical location.



### POSTGRADUATE COURSES FOR NEGRO PHYSICIANS IN MISSISSIPPI

Fifty-five of the 58 Negro physicians of Mississippi were reached by the postgraduate course in maternal and child care. With few exceptions these physicians are under 45 years of age. They are alert, interested, eager, and aware of health conditions among Negroes within their respective areas. Their medical effectiveness has a creditable relationship to their opportunities and economic competence. The majority of them are graduates of Meharry Medical College. Except for the occasional and extraordinary privilege of listening to a local medical lecture, no opportunity for medical advancement previously had been afforded them within the State. — Maddux — *The Child*, Feb. 1939.

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# **"FOOTSTEPS," DOCUMENTARY FILM, TELLS DRAMATIC STORY OF THE AMERICAN RED CROSS NURSE**

A one-reel motion picture entitled "Footsteps," which dramatically portrays the training of the Red Cross Nurse and the humanitarian work she performs has been prepared for free distribution by the American Red Cross. The purpose of this documentary film is to acquaint the public with the scope and nature of the activities of the Red Cross in behalf of mankind.

The picture begins with a scene of a girl walking into a nurses' training school. It then illustrates the intensive education given the student, with interesting and colorful glimpses of the inside of a great hospital. Classroom lectures, laboratory research, bedside practice, operating room procedure are introduced without the slightest suggestion of the morbid.

The training sequence ends with graduation services in which the young women repeat the Nurses' oath, part of which follows: "I solemnly pledge myself before God and in the presence of this assembly to pass my life in purity and to practice my profession faithfully."

"Every year," explains the narrator (Milton J. Cross), "approximately 20,000 nurses take this oath, following in the footsteps of Jane Delano, wartime head of the Red Cross Nursing Service."

The Red Cross invites all graduate nurses to enter its service. They can serve in three different classifications: first, as reserve nurses to be called in time of great need. "Footsteps" gives striking views of what such devoted volunteers do in time of war, in hurricanes, floods, epidemics. These scenes were made up from the Red Cross film archives photographed at actual locations as the Red Cross swung into action to succor the victims of catastrophes.

"In peace as well as war," says the narrator, "the Red Cross meets the challenge of destruction. In one year 129 different disasters struck the continental United States, many of them major calamities affecting countless thousands of our fellow-Americans. Almost overnight, the Red Cross mobilized a huge army of nearly 4,000 nurses in one disaster alone to serve without rest until all the victims were properly cared for."

The second path is that of Home Hygiene Nursing. The nurse instructs her community in the care of the sick and injured, the avoidance of contagion, and other matters that make for the well-being of humanity. Juniors are trained to take care of home and the ill. "Many a mother in an emergency has found that having a daughter who has been trained in Red Cross Hygiene is a blessing indeed," comments the narration.

The final sequence pictures the self-sacrificing work of the Red Cross Public Health Nurse who serves in remote sections where doctors, nurses and hospitals are few. She is a veritable angel of mercy to the old and infirm, the ailing, the injured, the anxious mother of a sick brood. "No community is too isolated, no home too humble to receive her call . . . Each year Red Cross Public Health Nurses make more than a million calls — and oftentimes, by discovering infectious disease at its inception, they save a whole community from epidemic."

The film shows the hardships and difficulties these nurses face in their work. "Bad roads . . . no roads . . . winter and summer . . . in blizzard and storm . . . she drives onward . . . always onward . . . What may seem drudgery to the uninitiated is to her an intensely satisfying life. She glows ever with a spirit that endears her to young and old . . . Whether she arrives to save a life or help to bring a new life into being, she never falters . . . Her footsteps follow an eternal path into the homes and hearts of all who need her help."

"Footsteps," a William J. Ganz Production, is available for free loan to churches, colleges, schools, clubs and other organizations. It may be had in standard 35-millimeter size or in 16-millimeter size without cost (except for a slight transportation charge) by writing to Douglas Griesemer, director of public relations, American Red Cross, 19 East 47th Street, New York City.



## **NO POLITICAL TIES**

Many physicians and laymen are asking whether there is any tie between organized medicine and the Gannett Committee which is fighting the Roosevelt Administration and the New Deal. The answer to this question is an unequivocal "No."

Organized medicine has no part in partisan political controversies. There is as much variation in the political ideas of physicians as of any other cross section of the public. Medical organizations have neither the desire nor the right to impose a political credo upon their members.

The Gannett Committee is fighting compulsory health insurance as part of its general attack upon the New Deal and increased governmental domination of the individual. Physicians are opposed to compulsory health insurance because they consider it a costly, cumbersome way to deliver inferior medical care. Agreement on this one point does not mean a general political alliance.

*Ed. — N.Y. State Jour. Med., May 15, 1939*



### WISCONSIN EXPERIMENT IN COOPERATIVE MEDICINE

The Douglas County (Wis.) Medical Society, in cooperation with the State Medical Society of Wisconsin and the Cooperative Health Association at Superior, has concluded an agreement to provide members of the association with complete medical and surgical care on a prepayment basis for a period of trial and study, *The Journal of the American Medical Association* for Jan. 14 reports.

In the preface to the agreement that was signed the following statements were made:

In September 1938 the State Medical Society of Wisconsin adopted the report of its Special Committee to study the distribution of health service and sickness care in Wisconsin. That report recommended that there be instituted under the direction of a special committee and the local county medical society, and with the assistance of lay groups actively interested in proposals dealing with new methods of the delivery of sickness, care, experimental voluntary plans providing sickness care on a prepayment and voluntary basis. To assure that any such plan create no health hazard to those seeking services under it, and to make certain that any subscriber should obtain those services contracted to be given, even though the fee basis should prove inadequate and the compensation not that which the Cooperative expects, the State Medical Society adopted as a requirement that the local medical society stand guarantor that the services be given and their quality be high. In other words, the actual reserve would be the physicians of the community. The State Medical Society of Wisconsin

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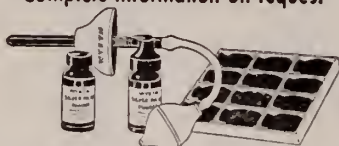


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sin and the Douglas County Medical Society have agreed that the Cooperative Health Association of Superior offers a proper situation for such experiment, and thus the two medical societies and the Cooperative state these principles, in the form of articles of agreement, to be followed in developing such a voluntary plan in Superior, Wisconsin.

The agreement provides that those who become members of the Cooperative Health Association shall have free choice of physician among the members of the Douglas County Medical Society; that a joint conference committee be established to meet regularly to discuss problems that may arise; that not more than 20 per cent of the membership dues shall be subject to administration charges; that 80 per cent of the gross income should be earmarked for physicians' services, and that no more than 300 units would be encompassed in the trial. Units may represent individual membership or family memberships. The total number of people participating in the trial, it is estimated, will reach a total of 1,200 individuals. The amount of monthly dues

has not as yet been established by the Cooperative Health Association. However, \$3 a month for complete medical and surgical care for an entire family has been tentatively considered. For a couple or for a single person the dues would be less. The plan does not include hospitalization costs, as the members of the association plan to avail themselves of the statewide group hospitalization plan now being effected by the society in cooperation with the hospital associations. The society emphasizes that the premiums established were accepted by it "without expression of judgment" as to sufficiency. The plan does not limit the participants to any stipulated income group.



## CLINICAL CONGRESS

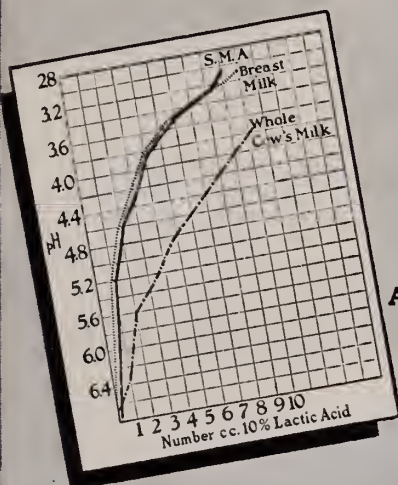
Preliminary program of the next Clinical Congress for September will appear in the July issue of the Journal.

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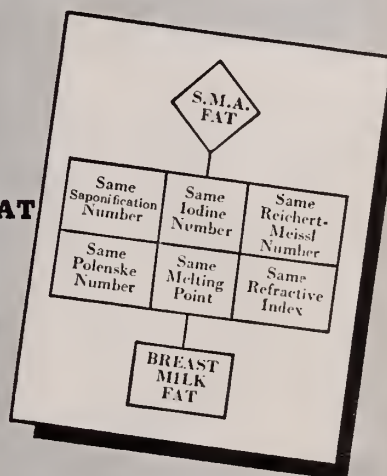
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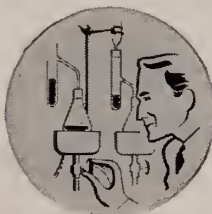


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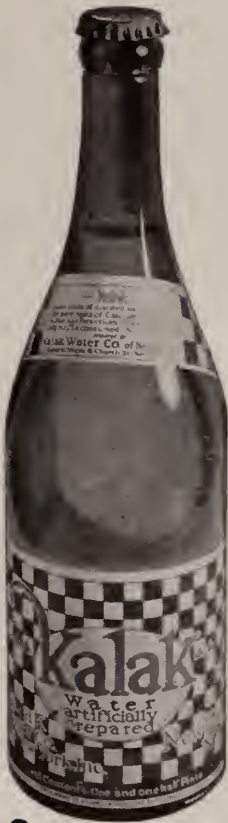
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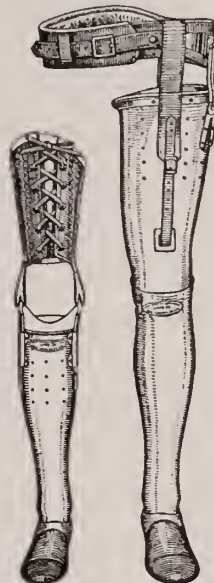
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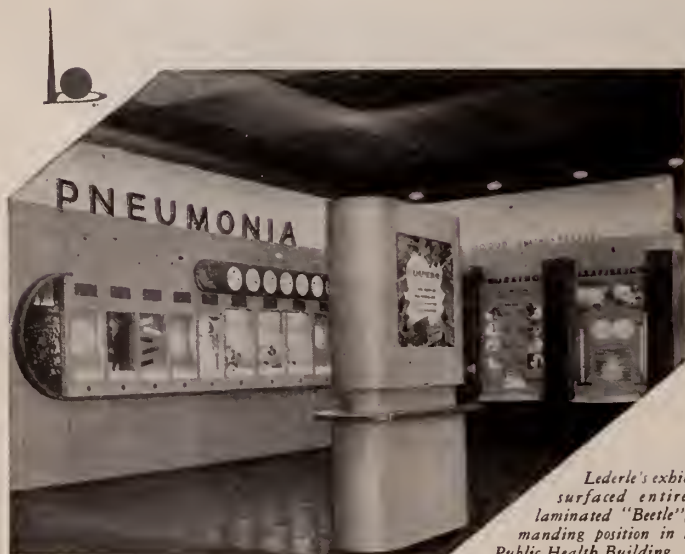
- 1—collect sputum for typing;
- 2—take specimens for blood culture and blood count;
- 3—then begin administration of Sulfapyridine;

But give serum also:

- if patient's temperature, pulse rate and respiration are not essentially normal within 24-36 hours after beginning the drug treatment;
- or if the case is of 3 days' or more duration;
- or if bacteremia is present;
- or if the patient is over 40;
- or if two or more lobes are involved;
- or if patient is pregnant or in first week of puerperium;
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## Cutaneous and Systemic Manifestations of Lymphogranuloma and Its Differential Diagnosis\*

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Because of the unusual interest being manifested throughout the whole country in the control of venereal diseases, I feel that a discussion of venereal lymphogranuloma might well be worth our while at this time.

Connecticut physicians may take particular pride in recalling that the first report of a case of this disease in America was presented in 1928 by three New Haven men, Hillsman, Wilshusen and Zimmerman.<sup>1</sup> Even though the Frei test was not then in use in this country, having been originated only about three years previously, their case history, including photographs and autopsy, was so completely worked up as to leave no doubt in anyone's mind as to the correctness of their diagnosis. They cited an earlier article by Pardo-Castello,<sup>2</sup> of Havana, Cuba, in which several cases had already been reported.

When Hillsman, Wilshusen and Zimmerman reported their one case they probably had little idea of the widespread attention which this disease would occasion in a few years. This interest has been due in large measure to the fact that the Frei test has made it possible to secure a definite diagnosis of venereal lymphogranuloma in a variety of conditions to which many other causes had been ascribed heretofore, and which had been diagnosed variously as colitis, proctitis, stricture of the rectum, carcinoma, syphilis or Hodgkin's disease.

### Occurrence

Venereal lymphogranuloma is a worldwide disease, affecting all races indiscriminately. In

the past few years at the Vanderbilt Clinic and at the City Hospital I have seen more than two hundred patients with this disease. While the greater number of these patients were negroes, I have observed the presence of lymphogranuloma in all races, most frequently in the lower classes and particularly in seafaring men. I had formerly associated this disease with filth and a low scale of living, but recently I have noted in medical literature that others have found it in all classes of society and just as frequently in whites as in negroes.

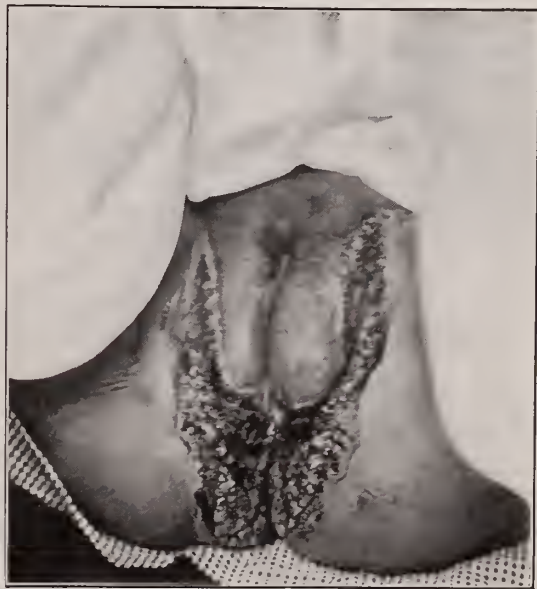


Fig. 1. Venereal lymphogranuloma; hypertrophy of left labium.

\*Read at the 146th Annual Meeting of the Connecticut State Medical Society, Groton, June 1, 1938.

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Chapman and Hayden<sup>3</sup> stated in 1937 that during the previous three years they had treated thirty white persons, representing all social levels, in both their private and hospital practice. Their opinion was that venereal lymphogranuloma in many instances passes unrecognized and undiagnosed in white people, mainly because of the fact that it has for so long been confused with other conditions, such as malignant tumors, tuberculosis, Hodgkin's disease, other venereal diseases or simple traumatic infection.

### Stages of the Disease

For simple study we may divide the course of venereal lymphogranuloma into three stages:

1. The primary, or chancre, stage
2. The secondary stage, in which the inguinal glands become enlarged and constitutional symptoms, such as malaise, headaches, anorexia, fever and loss of weight sometimes develop.
3. The tertiary stage, in which one may see gummatous ulcerations of the skin and subcutaneous tissue, sinus formation, sclerosis and elephantiasis, rectal stricture and arthritis.

The primary or initial lesion, while usually found on the foreskin in the male, or on the labia in women, may appear on any part of the external genitalia, or even extra genitally on any cutaneous or mucous surface. The incubation period is usually around fourteen days, though it may vary from six or seven days to a few months. The lesion is so small and insignificant as frequently to be unnoticed even by the patient and, as a consequence, the physician is often not consulted until adenopathy appears. When visible it is usually small, eroded and raised, and varies in size from that of a millet seed to that of a split pea. It is soft, only slightly reddened, and often a clear, slightly yellowish serum oozes from it. It never becomes very large, and usually disappears in about a week or ten days without treatment.

The secondary stage: In from two to six weeks after the disappearance of the initial lesion, or even before it is entirely gone, the inguinal glands on the side draining the sore become enlarged. This swelling increases slowly, the glands becoming soft in the center and moderately tender upon pressure. Finally after about six to nine weeks they rupture, discharging a thick, greyish-yellow, often slightly blood-

tinted, pus-like material. The wound gradually heals after a few weeks and the patient is discharged, but usually returns in a few months or years with another bubo, sometimes in the same area and sometimes on the opposite side.

Tertiary stage: Not infrequently the condition becomes chronic and a large sloughing ulcer develops, which burrows down through the inguinal region, along the sides of the scrotum, the crotch and around the anus. Occasionally the infection may penetrate under the skin in the suprapubic region and in the lower portion of the abdomen, forming large areas of cellulitis, with redness, swelling and multiple sinuses which turn into deep, sloughing ulcers. Often the skin of the glans penis and of the prepuce becomes a hard shiny, edematous mass with ulcerations around the base of the prepuce which sometimes extend into the urethra and produce a stenosis, with hypospadias. The ulceration, or sclerosis, is sometimes so extensive as to destroy the main portion of the penis, so that what remains of it has to be amputated, as was the case recently with one of our patients.

Gutman<sup>4</sup> of Presbyterian Hospital, New York City, says that 140 patients admitted to the hospital in the past one and one-half years had positive Frei tests. Thirty-three out of 135 of this group had symptoms of rheumatism in all stages. These symptoms varied from mild, recurring polyarthritic pains to symptoms of acute rheumatic fever with redness, swelling, pain, fever and fluid in the joints. The fluid was clear and sterile. The joint symptoms subsided after a few weeks of rest in bed but often recurred.

Boots<sup>5</sup> has treated sixteen cases of arthritis attributed to lymphogranuloma in his arthritis clinic at the Vanderbilt Clinic. All had positive Frei tests and no other cause could be found for the arthritis. All had secondary anemia and symptoms of general malaise.

Of the patients who came to the Medical Clinic with symptoms of acute chronic intestinal obstruction none was aware of a rectal stricture. Some had diarrhea and bloody stools with mucus and pus. Roentgenograms showed the rectum, ascending colon and even the transverse colon to be affected. All the patients had secondary anemia, the hemoglobin averaging about fifty per cent, and the red blood cells around 3,000,000. Erythema nodosum appeared many times. The sedimentation rate and serum protein values

were very high in all instances, the latter even more so than is usual in myeloma. Eighteen per cent of the patients had anticomplementary Wassermann tests. It was thought that there was a possible link between this finding and the high serum protein.



Fig. 2. Typical venereal lymphogranuloma ulcer showing flat, red, granular base; few areas of grayish-yellow slough; sharply margined, raised, slightly undermined edges. Scarring and vitiligo of scrotum and adjacent parts.

There have been reports in the literature of meningitis, convulsions, interstitial keratitis, a variety of insignificant skin rashes mostly of an id-like character, and even sarcoid, which were said to have been due to lymphogranuloma. I must confess, however, that I myself have never observed these phenomena in any of the many cases I have seen. I am inclined to believe that such symptoms must be exceedingly rare.

#### Course of the Disease in Women

Because of the drainage mechanism in the female pelvis one seldom finds any lymphogranulomatous involvement of the inguinal glands in women, but the perirectal and other pelvic glands become enlarged. Often the labial ulcerations will end in sclerosis and hypertrophy, the labia majora or labia minora, and frequently the clitoris also, reaching such an enormous size that they interfere with the patient's locomotion. Sometimes the labial and vaginal ulcerations extend into the groin and

along the crotch to the anus (esthiomene), becoming so extensive and so severe as to cause great mutilation of the parts. The ulceration of the cutaneous and deeper tissues extends along the border, and shows little or no tendency to heal at the center. The edges are sharply demarcated, slightly infiltrated and undermined, while the base is flat, yellowish-red and granular, with areas of thin, greyish-yellow slough. The rectum, when first affected, may be involved to a height of eight inches; it is red and swollen, with multiple necrotic ulcers the size of a pin-head or a millet seed dotted over the surface. There is usually a blood-tinged mucous discharge. As the condition becomes more chronic the amount of scar tissue increases, causing contraction and narrowing of the part so that the feces are only pencil-sized. A stricture has now been formed. The rectal walls become greatly thickened and the surface verrucous in appearance. The process usually extends into the colon. Or again, the colon may be involved without any signs of a rectal stricture except for the blood-tinged mucous discharge and the discomfort and pain in the lower bowel. The appearance of lymphogranuloma in the colon is similar to that in the rectum. It exhibits the same redness, swelling and multiple ulcerations and the scarring which sometimes develop into a stenosis.

#### Pathology

The pathology of venereal lymphogranuloma is not sufficiently characteristic to enable one to make a diagnosis. The pathologic picture varies much according to the type of the lesion studied, but the findings are usually of a simple inflammatory nature. Sections of the bubo show multiple abscesses, a few foreign body giant cells and small collections of epithelioid cells, but there are never any caseating tubercles such as are found in tuberculosis.

#### Diagnosis

As you recall, the Frei human vaccine is obtained by aspirating the pus from an unruptured bubo under aseptic conditions. The pus is diluted five to ten times with normal saline, and the material heated for one hour the first day and two hours the second day at a temperature of 60 C. Then 1/10 cc. is injected intracutaneously. If the reaction is positive, in forty-eight hours a large red papule half a centimeter in diameter or larger will appear, surrounded by a red areola and sometimes showing a central pustule. The





Fig. 3. Elephantiasis of right labium and clitoris with venereal lymphogranuloma of right vaginal wall

Frei test, it must be noted here, becomes positive only in the secondary stage of the disease.

Recently Paulson<sup>6</sup> of the Johns Hopkins Hospital devised a bowel antigen for intradermal use. A positive response with intracutaneous injections of this antigen indicates the presence of the virus of venereal lymphogranuloma in the material from which the antigen has been made. The material is collected by aspiration of secretions from the colon, following an irrigation, and prepared and administered in the same way as is the Frei antigen.

#### Differential Diagnosis of Venereal Lymphogranuloma and Other Similar Diseases

The initial lesion of venereal lymphogranuloma, while commonly characteristic in appearance, is at times mistaken for chancre, chancroid or herpes. It, however, always lacks the characteristic hardness of a chancre and the dark field is negative for *Spirochaeta pallida*. It differs from chancroid in that the chancroid spreads rapidly, has a sloughing base and undermined and ragged edges, with an areola of redness around the lesions. Usually Ducrey's bacilli can be demonstrated in secretions taken from the chancroidal ulcer. Chancroid also gives a positive dmecost test.

The lesions of herpes progenitalis are strikingly similar in appearance to the initial lesion of ve-

neral lymphogranuloma. They are usually multiple, however, and likely to be much redder and more papular than lymphogranuloma lesions. In the second stage of lymphogranuloma, before there is any evidence of breaking down of the gland, one might suspect syphilis. In lymphogranuloma, however, the whole group of glands is enlarged and matted together, forming an irregular, immovable mass, while in syphilis there is usually one solitary gland, freely movable and not tender to pressure.

Granuloma inguinale is frequently confused with venereal lymphogranuloma, not only because of a similarity of names but also because in some of the late stages the two diseases bear a close resemblance to each other. For example, both are likely to produce elephantiasis of the labia and prepuce, and both produce indolent ulcerations around the genitals, anus and crotch. We have to remember, however, that granuloma inguinale is essentially a disease of the skin, while venereal lymphogranuloma is a disease of the lymphatics and spreads through the lymphatic channels. The ulcers characteristic of the two diseases are quite different: that of granuloma inguinale is usually a red, fungating, granular, budding ulcer with rolled edges. It spreads at the margin and has a tendency to heal in the center with scar formation. Donovan bodies may be demonstrated in smears taken from se-

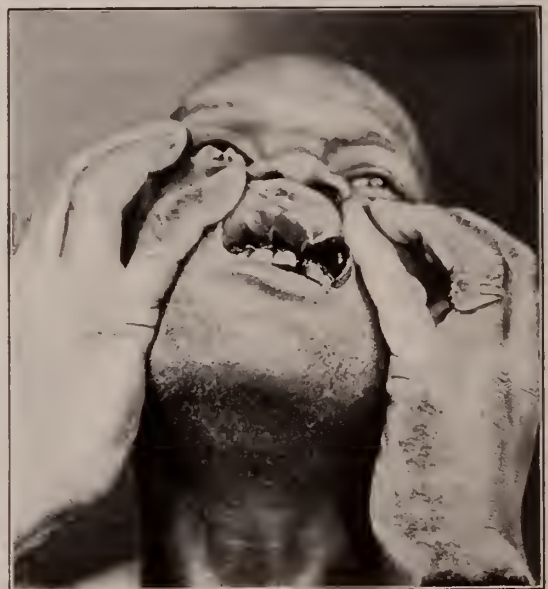


Fig. 4. Unusual case of granuloma inguinale involving buccal mucous membranes.



cretions at the edge of an inguinal granuloma. The ulcer of venereal lymphogranuloma, on the other hand, has a smooth base, with some red and granular areas, and others covered with superficial greyish-yellow slough. The borders are slightly undermined and raised, the lesion shows no tendency to heal in the center, and one does not see in or around the lesion the budding fungating, papular, pea-sized ulcerations which are characteristic of inguinal granuloma.

Tuberculosis is often suspected chiefly by reason of the presence of ulcerating skin at the site of a broken-down bubo. The edges are often slightly warty, a bit elevated and are sometimes one-half inch wide at the border of the ulcer. These ulcers differ from tuberculosis in that there is no tendency to scarring, and that the apple-jelly nodules found in tuberculosis are absent. Tubercle bacilli cannot be found in smears taken from the margin of the sores, and the characteristic histologic picture of tuberculosis is absent.

Sometimes the ulcerations at the margin of the anus and that of the genitalia, especially of the glans penis and the cervix, may bear a striking resemblance to carcinoma, but the typical hardness always found in carcinoma is absent, as are the hard, enlarged glands.

It is sometimes difficult to distinguish gumma from an infiltrating subcutaneous venereal lymphogranuloma, with swelling, redness and multiple sinus formations. Venereal lymphogranuloma is painful, the discharge of pus tinged with blood is more abundant, and the sloughing is not so marked as in gumma. The Wassermann test is often helpful in making a differential diagnosis, although it must be remembered that the Wassermann test may also be positive in the early stages of venereal lymphogranuloma. When that is the case, one must always consider the possibility that both diseases are present together.

Hodgkin's disease may occasionally be suspected in venereal lymphogranuloma, but the latter disease is of a much more inflammatory nature, the glands are not so large and they usually show signs of tenderness, redness and fluctuation, symptoms not seen in Hodgkin's disease.

One must always differentiate an ordinary proctitis and an idiopathic colitis with rectal strictures from those occurring as a part of the

picture of venereal lymphogranuloma. This can usually be done in the case of a stricture by the Frei test and by the Wassermann reaction, and in colitis or proctitis by the Frei test and by the clinical appearance of the mucous membranes of the rectum or colon. In lymphogranuloma these are usually red and swollen and studded with red, punctuate ulcers. A discharge of pus, blood, mucus and sometimes feces containing pus is ordinarily noted.

### Treatment

Treatment of venereal lymphogranuloma must depend upon the stage of the disease, and may be either local, medical or surgical. The chancre, when present, should be cauterized, either with actual cautery or by an application of formaldehyde, phenol or silver nitrate.

The adenopathy is best treated by giving 1-1¼ roentgen units filtered through 2 mm. of aluminum, repeating the exposure if necessary in three to four weeks. In addition to the radiation we have had success in administering intracutaneous injections of vaccine, every three to five days, around the bubo. Sometimes, however, it is difficult to evaluate the results of this treatment, inasmuch as the enlarged glands frequently disappear spontaneously.

Once an abscess has formed, as evidenced by fluctuation, we have found it beneficial to aspirate the pus, using a 19-gauge needle and a tightly fitting 20-30 cc. syringe, and to irrigate the cavity three or four times with ten per cent phenol.

Ulcerations of the skin we have treated by daily cauterization with ten per cent phenol, application of wet dressings of normal salt solution, and intracutaneous injections of vaccine around the ulcerations. We have also administered the vaccine intravenously and subcutaneously at all stages of the disease, with, we believe, a fair degree of success. Sometimes it has been necessary to use a vaccine over a five to six months' period. Under this treatment the pain and discharge of rectal strictures and colitis were noticeably decreased and ulcers healed, though slowly. We have also given sterile milk intramuscularly, and typhoid vaccines intravenously, as fever-producing agents. We noted just as much improvement following the use of these remedies as with that of the Frei vaccine; in fact, in some instances the improvement was even more marked.

We have treated a number of cases of lymphogranuloma with a modified Kettering fever box machine, and have had some surprisingly beneficial results, especially in relieving the pain and decreasing the rectal discharge and rectal stricture. Ulcerations have healed well under this treatment. We endeavored to keep all the ulcers as clean as possible by the use of soap and water and by rectal and colonic irrigation of the wounds twice a day. In addition to this we have given our patients a high caloric diet, with liver extract, viosterol, haliver oil and vitamin C tablets. We have also used tartar emetic in a great many cases, but with very indifferent results. Cave<sup>7</sup> of Roosevelt Hospital, New York City, reports that in a communication of recent date Dr. Vernon David of Chicago stated that he had had two spectacular cures of rectal stricture and colitis by giving sulfanilamide in doses of ninety grains a day. The improvement was immediate. These patients previously had had all the usual treatment for the disease but without benefit. David strongly recommends the use of this drug, as well as all other methods of treatment, before resorting to surgery.

The surgical treatment of venereal lymphogranuloma, while somewhat restricted in scope, is not only indicated but is imperative in certain types of the disease. This surgery is largely plastic in type, and is confined to the amputation of large pendulous growths of the labia, clitoris and sometimes the prepuce. It may even be necessary sometimes to do a suprapubic cystotomy. While some surgeons advocate excision of all inguinal glands, we have never followed this procedure, believing that the treatment outlined above is not only more efficacious but certainly less radical. It never produces the elephantiasis of the extremities which occasionally follows surgery.

In the past year or so a number of surgeons have advocated the removal of the colon and rectum, and also colotomy. Their contention is that there is an immediate improvement in the condition although the disease is not cured. Sometimes the sinuses persist. Grace has removed four colons at Bellevue Hospital during the past year, and Cave at Roosevelt Hospital has removed six, both securing favorable results in all cases.

### Summary

Venereal lymphogranuloma is a systemic venereal disease which, while occurring in all races in this vicinity, appears to be found more frequently in negroes. It is associated in our minds with filth, and is due to a filtrable virus.

The course of the disease may be divided into three different stages: primary, secondary and tertiary.

Patients may become spontaneously cured in the early stages but the tendency is for the disease to become chronic, producing ulcers with marked destruction of tissues in the pelvic region. Sinuses, elephantiasis, rectal and colonic ulcerations with stricture of the bowels and arthritis are all frequent concomitant symptoms.

Practically all patients show a secondary anemia, usually of a moderate degree. All have a very high serum protein; about eighteen per cent have anticomplementary Wassermann reactions. Erythema nodosum is not uncommon.

Venereal lymphogranuloma must be differentiated from other venereal diseases, carcinoma, tuberculosis and Hodgkin's disease. The diagnosis is greatly aided by the Frei test.

The treatment varies according to the stage in which the disease is found, and is local, medical or surgical, as the case may require. Human Frei vaccine has been found beneficial, as has also fever therapy. Sulfanilamide has been markedly beneficial in clearing up rectal and colonic ulcerations where other remedies have failed.

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# Cancer of the Stomach\*

## An Analysis of 42 Cases

L. G. SIMON, M.D.

Norwalk, Conn.

### Introduction

With the establishment of the tumor clinic at the Norwalk Hospital several years ago, interest in cancer has grown markedly. Along with improved handling of present cancer problems, speculation also developed as to previous results in cancer treatment. The writing of this paper was stimulated by this curiosity.

This analysis includes 42 cases treated at the Norwalk Hospital from October 1932 to October 1938.

### Incidence

There seems to be general agreement among all writers on the subject, that cancer of the stomach is the most common cancer in males and is only next in frequency to cancer of the uterus and breast in females. Various authors claim that this disease accounts for from 18%(4) to 35%(6) of all deaths from cancer. In Connecticut the percentage is 22.8 and in Norwalk, 31.3(7). These figures do not seem to coincide with the average clinical experience. This is partly due to the errors in the reporting of the disease. Connecticut, for instance, includes this condition under "stomach and liver," while according to the International List of Causes of Death, cancer of the stomach is listed under cancer of gastro-intestinal tract. Furthermore, many deaths reported from cancer of the stomach are unsubstantiated by either X-ray, operation, or autopsy.

### Age, Sex, Color

The age incidence is shown in Table 2. The greatest number occurring between the ages of 50-70. That the disease is predominant in the male is shown by its presence in 25 males. Forty patients were white.

### Symptoms

The universal cry in the attempt to reduce the mortality from this disease is "early diagnosis."

Table 1

<i>Year</i>	<i>No. of cases</i>
1932 - 3	6
1933 - 4	2
1934 - 5	8
1935 - 6	8
1936 - 7	9
1937 - 8	9
	—
Total	42

Cases of Cancer of Stomach  
admitted to the Norwalk Hospital

Table 2

<i>Age</i>	<i>No. of cases</i>
21 - 30	0
31 - 40	1
41 - 50	2
51 - 60	16
61 - 70	15
71 - 80	7
81 - 90	1

Table 3

<i>Complaint</i>	<i>No. of cases</i>
Pain	24
Distress	4
Weakness	4
Loss of wt.	3
Vomiting	2
Hemorrhage	2
Dysphagia	1
Tumor	1
Diarrhea	1

Presenting symptom

\*Read at a staff meeting of the Norwalk General Hospital, Norwalk, February 21, 1939. Also read (in part) at a joint meeting of the Fairfield County Medical Societies, Norwalk, February 8, 1939.



Practically all the cases in this series were late cases. It was not possible to determine the earliest complaints from our records, nor was it possible to note the order of their appearance. However, the presenting chief complaint on admission was obtained and tabulated, as well as the various symptoms with their frequency of occurrence.

Epigastric pain was the most frequent and the most important complaint. Most of the patients also had loss of weight, nausea, vomiting and indigestion. The average weight loss was not obtainable. In another series it was reported as 25.7 pounds<sup>4</sup>. Waiting for the above symptoms to appear in order to diagnose cancer of the stomach would not help in the fight against the disease. The important point is to investigate every patient with "gastric consciousness." One must remember that in early gastric cancer, all symptoms may vanish under medical treatment.

**Table 4**

<i>Symptom</i>	<i>No. of cases</i>
Loss of wt.	33
Pain	32
Nausea and vomiting	29
Indigestion	30
Tumor	10
Constipation	7
Hemorrhage	5
Tarry stools	3
Diarrhea	2
Frequency of symptoms	

#### Family History

In only one out of the 42 cases was there a history of carcinoma in the family.

#### History of Ulcer

In four cases a history was obtained of a chronic peptic ulcer. This sheds no light on the controversy as to whether gastric ulcers become malignant.

#### Diagnosis

Definite diagnosis of cancer of the stomach can usually be established by X-ray examination, microscopic study, or abdominal exploration. An additional new method is that of gastroscopy, as described by Schindler. In 31 of the 42 cases an X-ray study was made. A diagnosis of malignancy was made in every one of these cases,

except one (where an ulcer was diagnosed). This record serves to emphasize the tremendous value of X-ray in the early recognition of cancer of the stomach. In the cases not X-rayed, the diagnosis was made either by an exploratory laparotomy or an autopsy. Gastric analyses were not resorted to very much. Only five cases were examined by this method. All of these, however, did show a total or a very marked achlorhydria, corroborating the diagnosis and suggesting the further use of this diagnostic aid. Hinton stresses gastric analysis as the most valuable aid in calling attention to early cancer.

#### Pathology

There is no unanimity as to the classification of cancer of the stomach. The classification used here is that of Ewing. Histologically, there were 20 adenocarcinomata, 1 lymphosarcoma, 1 carcinoma simplex and 20 that did not come to either autopsy or biopsy. Grossly, there were 12 infiltrating ulcero-cancers, 6 bulky adenocarcinomata, 6 carcinomata simplex diffuse, 1 linitis plastica, and the rest not examined. As to location of the lesion, there were 16 on the lesser curvature and cardia, 14 in the pyloric region, 5 affecting the whole stomach, 3 on the greater curvature, and the rest (4) undertermined. Metastases were present in the following distribution:

Regional lymph nodes and liver	17
Ovary	1
Lungs	3

There were no metastases to the supraclavicular node.

**Table 5**

<i>Location</i>	<i>No. of cases</i>
Lesser curvature and cardia	16
Pyloric region	14
Whole Stomach	5
Greater curvature	3
Undertermined	4

#### Location of Lesion

#### Treatment

Treatment of cancer of the stomach is entirely surgical. Pack and Scharnagel<sup>6</sup> described a method of palliative therapy by irradiation. This is of use in inoperable carcinoma. Of the surgical methods of treatment there are: (1)

total or partial gastrectomy, which is considered as radical treatment, and (2) gastroenterostomy, which is palliative in character. Operability is determined by the patient's general condition, the presence or absence of metastases, and by the possibility of removing the entire growth. From a study of the results of treatment at the Presbyterian Hospital in New York, the conclusion is drawn that the "greatest factors in longevity, where radical surgery has been possible, are the biological characteristics of the tumor, referred to by Stout as the 'fungating' type, and the absence of metastases."

Table 6

Operation	Total	Dead	Alive	Unknown
Total				
Gastrectomy	1	1		
Partial				
Gastrectomy	6	3	2	1
Gastro-				
enterostomy	6	4	1	1
Gastrostomy	1	1		
Exploratory	6	5	1	
Inoperable	22	20	1	1

## Operative results

At the Mayo clinic 50% of all gastric carcinomata, when first seen, are considered hopeless so far as operability is concerned. At Memorial Hospital in New York 20% are considered operable. Our percentage coincides with this experience (as shown in Table 6). Twenty of the forty-two cases were operated upon. "Operability" in our cases did not mean a planned removal of the tumor, but rather a condition wherein the patient was well enough to be explored surgically and the mode of the treatment determined at the laparotomy. Only seven cases were treated with the hope of cure. The case upon which total gastrectomy was performed, was a diffuse carcinoma involving the lower half of the stomach. It was complicated by the presence of diabetes. In the partial gastrectomy group, two patients are alive,  $1\frac{1}{2}$  and  $3\frac{1}{2}$  years respectively. There is a recurrence, evident on X-ray, now present in the latter case. Another patient is alive one year after a gastroenterostomy and one 3 years after an exploratory operation. In this last case a tumor was felt at operation and was considered inoperable. Only

the survival of the patient casts some doubt on the diagnosis. One case, considered in too poor a condition for operation, is alive two years after admission, in fair condition.

Considering all types of treatment, about 5% of all cancers of the stomach can expect to be cured<sup>3</sup>. We have no five-year cures to report, but a 10% survival of from one to three and one-half years. It is estimated that of all cancers seen, including those recognised very early, 25% are suitable for resection. Our percentage was about 19, but no early cases at all were seen.

## Comment

It is noted that there were no early cases in the group. The admission of cases in earlier stages of the disease should be striven for. One should not wait for the classic textbook symptoms to appear, but should X-ray every patient with "gastric consciousness." The prohibitive cost of X-ray photographs enter into the situation, and it is our belief that steps should be taken to make this most important diagnostic aid available to all.

## Summary

A series of 42 cases of cancer of the stomach is analyzed. The incidence of the disease is discussed. An emphasis is made on the apparent discrepancy in the clinical incidence as against the statistical incidence. No early cases were seen in this series. An appeal is made to X-ray all cases with "gastric consciousness" in order to discover more cases in earlier stages of the disease. The accuracy of X-ray in diagnosis is demonstrated. The pathology of the disease is discussed and the results of treatment are tabulated.

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## Studies in Convulsant Therapy

### III. Treatment of Long-standing Functional Psychoses with Metrazol: Results and Theory of Action\*

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#### Introduction

Since Meduna's original publication in 1935 (1), more than 400 papers have appeared on the treatment of various psychiatric disorders with pentamethylentetrazol (known in this country as metrazol, elsewhere as cardiazol). Our justification for adding to this large number lies in the fact that our clinical material differs considerably from that of most other investigators, consisting as it does of patients with psychoses of relatively long duration, in whom previous treatment by other than shock technique had failed.

The present report, third of a series of studies in convulsant therapy, dates back to August, 1937, when the work was first begun, and includes data on 47 patients in whom treatment has been completed for a period of at least three months; thus sufficient time has elapsed to provide us with a reasonably fair estimate of our initial results.

Although metrazol is to be regarded in this study as the principal therapeutic agent, in actual practice we have always supplemented it as much as possible by various other recognized procedures. In those cases where indifference and withdrawal from reality were not of a degree to prevent it, individual treatments were preceded and followed by psycho-therapeutic interviews. Particular attention was given such matters as routine hospital activities, personal hygiene, recreational interests, and occupational and industrial therapy. In suitable cases prompt steps were taken to bolster the patients' morale by granting various privileges, such as hospital parole, home visits, and advancement of the patient in the social scale of the hospital community.

In presenting our material, we should like to call particular attention to two problems that have not yet received sufficient consideration:

1. The role of metrazol in the treatment of

so-called chronic cases, not alone from the viewpoint of attaining remissions, but also of alleviating certain symptoms that affect the well-being of the hospital itself, among these being assaultiveness, destructiveness, untidiness, and idleness.

2. The value of metrazol in the treatment of psychoses other than schizophrenia, especially the manic-depressive group. Although our series in the latter group is at present very small, we have been so impressed with our results as well as with the reports in the literature, that we consider it important to call attention to the matter at this time.

In order to view these problems in their proper perspective, a brief review of the history is indicated. Meduna was first inspired to attempt convulsant therapy by certain observations which seemed to indicate that schizophrenia and epilepsy were incompatible. He therefore postulated a "biological antagonism" between the two conditions. Experimenting with various convulsant drugs, he finally selected metrazol as the ideal, then proceeded to treat a group of schizophrenics with remarkable success. Although his method has been generally acclaimed, his theory has never won wide acceptance, a fact which need not, however, detract from the basic importance of his discovery. Today the necessity for a more comprehensive theory is becoming increasingly apparent, as more and more reports appear on the successful treatment with metrazol of various "functional" psychoses other than schizophrenia. Thus, Bennett (2) has claimed uniformly good results in twenty-one cases of chronic agitated and stuporous types of depressive psychoses, eight of whom were past the age of fifty-five. He states that metrazol more consistently shortens the period of treatment than any method previously described, and that it is relatively safe even in pre-senile patients

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who are in good physical condition. Other reports have appeared from Wahlman (3), Becker (4), Dombrowski and his co-workers (5), Steinberg (6), Owensby (7), Low and his co-workers (8), Goldstein and his co-workers (9), and Bookhammer (10) — and have variously included such conditions as involuntional psychosis, manic-depressive psychosis, chronic alcoholic psychosis of the paranoid type, and anxiety neurosis. The consensus of opinion in this group of investigators seems to be that metrazol is of especial value in the depressions of the manic-depressive and involuntional types, and that these conditions respond to much less treatment than the schizophrenic group.

Ease of administration and relative freedom from complications are among the important advantages of metrazol therapy. With the patient in bed, about two hours after breakfast, the drug is given in 10% aqueous solution by very rapid intravenous injections, starting with a dose of 4 cc. The treatment is repeated every other day, and as the patient's tolerance increases, it may be necessary to augment the succeeding doses by ½ cc. or 1 cc. increments in order to maintain the convulsant level.

Following the injection of a convulsant dose of metrazol, events usually follow with dramatic suddenness, the following phases being recognized: aura, precipitating phase, tonic phase, clonic phase, rest phase, automatic phase, and sleep. The convulsion proper, from aura through clonic phase, lasts less than a minute. As a rule the patient is ready to resume his usual activities within thirty to sixty minutes after the injection. With the onset of the tonic phase unconsciousness occurs, and since that is the criterion for a grand mal reaction, any part of the episode ending at or before the precipitating phase is to be regarded as a petit mal. The precipitating phase (a descriptive term coined at this clinic) is therefore important in interpreting the nature of the metrazol reaction. These phases are more fully described in another paper (11).

Contraindications to treatment are cardiovascular diseases, acute infections, severe head injury, and various systemic diseases such as active syphilis, tuberculosis, diabetes, nephritis, severe anemia, etc.

The cost of any treatment from an institutional point of view is important, and for metrazol it is quite low. By making up our own solutions the average cost of the drug per treat-

ment amounts to about fifteen cents. If we include in our estimation the time required of a physician, supervisor, and two attendants during each treatment — also miscellanea, such as sterilization, bottles, gauze, etc., we find that the total cost of treatment for six patients amounts to no more than \$1.75 per day, this not including additional time spent with patients in psychotherapy and various examinations.

Tabulation and Analysis of Results

The following tables summarize our experience with forty-seven patients, of whom forty-two are schizophrenics, four manic-depressives, and one psychosis with mental deficiency exhibiting a schizoid type of reaction.

TABLE I  
PERSONAL DATA

<b>A. Diagnosis</b>	
Schizophrenia	
Simple.....	3 patients
Hebephrenic.....	11 patients
Catatonic.....	10 patients
Paranoid.....	18 patients
Total.....	42 patients
Manic-depressive	
Manic.....	2 patients
Depressed.....	2 patients
Total.....	4 patients
Psychosis with Mental Deficiency.....	1 patient
Grand Total.....	47 patients
(36 males, 11 females)	
<b>B. Age Groups</b>	
15-20 years.....	2 patients
20-30 years.....	17 patients
30-40 years.....	22 patients
Over 40 years.....	6 patients
Average age.....	31 years
<b>C. Length of Hospitalization</b>	
½-1 year.....	1 patient
1-2 year.....	4 patients
2-3 years.....	13 patients
3-5 years.....	13 patients
5-8 years.....	7 patients
Over 8 years.....	9 patients
Average.....	3½ years.

Table 1 indicates in a general way the type of patient treated. The eldest was 45 years of age. The longest hospital residence was 12 years. Twenty-nine patients, or 57% of the total, had been hospitalized for more than three years. The average age of 31 years and the average hospitalization period of 3½ years serve to emphasize the relative chronicity of this group.

TABLE II  
METRAZOL DATA

A. Total Number of Injections.....	1290
Grand mal.....	918
Petit mal.....	372
B. Average Number Injections per Patient	
Schizophrenia	Other Psychoses
Grand mal..... 19	5
Petit mal..... 7	6
Total	26 11
C. Average Dose of Metrazol per Patient	
Schizophrenia.....	7.5 c.c.
Other Psychoses.....	7.0 c.c.
D. Average Length of Treatment	
Schizophrenia.....	50 days
Other Psychoses.....	22 days

Table II summarizes some of the data pertinent to the treatment itself. Of the total number of 1,290 injections, 71% were grand mal reactions. At first we attempted to increase the number of major paroxysms by subjecting the patients to thorough alkalization and hydration in accordance with Friedman's recommendation (12). However, subsequent studies at our clinic, as reported elsewhere (13), proved that such a procedure was apparently immaterial as far as the metrazol effect was concerned. Reference to Part B in Table II reveals important differences in the treatment of schizophrenia and manic-depressive psychosis, the latter requiring less than half the number of injections that were given to the schizophrenic group. Furthermore, the ratio of grand mals to petit mals is much greater in schizophrenia than in the other types, thus indicating that manic-depressives apparently have a considerably higher tolerance to the drug. These distinctions are further reflected in Part D where it is seen that manic-depressives require less than half the period of treatment that the others do. The number of days mentioned here indicates only the duration of metrazol administration itself. Actually, several more weeks may elapse before any change in the patient's condition may be seen. For that reason relatives should be informed that the total length of treatment is likely to be at least three months in the case of schizophrenia, and perhaps half that time in the other types. Part C is largely self-explanatory, indicating the average dose of metrazol per patient throughout the entire course of treatment. As a rule it is not necessary to exceed 10 or 12 cc., but in a few instances in which the tolerance has been unusually high, we have

given as much as 15 cc. in a single dose.

An interesting feature of metrazol therapy, and one that seems to belie its drastic nature, is the weight gain that frequently occurs. One patient gained 40 pounds within a period of three months. The average gain in weight was six pounds for the group.

TABLES III A TO III D

Results in 47 Cases

TABLE III A. ACCORDING TO DIAGNOSIS

	No Change	Improved	Remission With Defect	Complete Remission	Returned Home
Schizophrenia (42 cases)					
Simple		1		2	2
Hebephrenic	6	5	2		
Catatonic	5	3	1	1	1
Paranoid	5	6	3	2	7
Total No.	16	15	6	5	10
Per cent	38%	36%	14%	12%	24%
Manic-depressive* (4 cases)					
Manic		1		1	1
Depressed			1	1	1
Total		1	1	2	2
Psychosis with Mental Deficiency (1 case)			1		1
Grand Total No.	16	16	8	7	13
(47 cases) Per cent	34%	34%	17%	15%	28%

Table III A summarizes our clinical results according to the main diagnosis and the sub-classification, and shows these results both by number and percentage. In the "Improved" group we have placed those patients who have exhibited a definite amelioration of various distressing symptoms, with a consequent improvement in their hospital status, but without any profound effect upon the elements which form the intrinsic texture of the psychosis, such as emotional tone, content of thought, insight, judgment, etc. Thus, the correction of such indicia as idleness, negativism, untidiness, assaultiveness, and destructiveness, has, in our opinion, warranted the inclusion of a patient in this group.

\*Since this paper was submitted we have treated two additional manic-depressive patients. All of the six patients have had apparent remissions and have now returned home.



Under "Remission with Defect" are included those in whom the psychosis has subsided to such an extent that the individuals are able to make a satisfactory social adjustment outside the hospital. Abnormal mental trends, when present at all, have receded so far into the background that they no longer dominate the patient's behavior; in fact, close questioning may be required to reveal their presence. These patients frequently exhibit an externalization of interests that contrasts strikingly with their previous picture of preoccupation and apathy; at times this amounts almost to a mild hypomanic reaction. Insight, however, is superficial or lacking, and judgment is unreliable.

To the patients listed under "Complete Remission" are applied all the criteria of the preceding group with these additional qualifications — there must be no trace of any residual abnormal trends, insight must be complete, and judgment on a par with the intellectual level.

In spite of the rather artificial nature of the above classification, we cannot help but feel that it consists of fairly well-defined, recognizable groups, which, in the absence of more accurately measurable phenomena, are quite applicable to a study of this type. At the same time, however, it must be realized that the classification reflects only the events of the immediate present; for a patient who is considered as only improved today, may in time go on to a full remission; whereas, on the other hand, one in remission may eventually relapse into his previous psychotic status. Any consideration of the following tables should therefore be approached with these definitions and limitations in mind.

As indicated in Table III A, some degree of improvement was attained in 62% of the schizophrenic group, with remissions, both defective and complete, in 26%. The response of the sub-classifications to therapy occurred in the following order, from most favorable to least favorable: simple, paranoid, catatonic, and hebephrenic. One should note that this order corresponds roughly to the relative degrees of deterioration that usually occur clinically in these respective sub-groups.

Of the four manic-depressives, two have had complete remissions and have returned home; a third is expected soon to be eligible for home parole. One depressed patient who had a full remission and went home, had been hospitalized

for seven years before metrazol treatment was instituted. The outcome has in general been more striking in the depressed than in the manic type, but even in the latter results have been impressive. One of these is especially interesting, illustrating as it does for the first time an effective mode of treatment in a type of case that is usually regarded with apprehension and helplessness.

**Case Report.** S.U., age 16, with a diagnosis of manic-depressive psychosis, manic type, had been in a hypomanic state for five months, when he suddenly developed an acute delirious excitement of the type formerly known as Bell's mania. He was in a constant frenzy of motion, became negativistic, refused food, and gradually became emaciated. Tube-feedings were resisted and regularly regurgitated; finally, clyses of glucose and saline solutions were resorted to daily. He developed numerous superficial skin infections associated with a low-grade fever, became progressively worse, and was finally placed on our danger list. At that point, in spite of his precarious condition, metrazol therapy was instituted, beginning cautiously with 1 cc. and gradually increasing the dose at daily intervals until he had his first grand mal reaction with 4 cc. of the drug. Shortly thereafter he asked for food and continued to eat from then on voluntarily, gaining eight pounds in two weeks time. In all he had 24 injections, of which only 13 were grand mals, thus indicating a high tolerance to metrazol. His infections and fever rapidly subsided, and he gradually became quieter and more accessible. At the present time he is occupied in one of our outdoor industrial units and seems well on the road toward remission. We cannot help but feel that metrazol was a life-saving measure in this case.

III B. According to Length of Hospitalization

Length of Hospitalization	No Change	Improved	Remission With Defect	Complete Remission	Home Parole
½ - 1 year (1 patient)		1			
1 - 2 years (4 patients)	2	1		1	2
2 - 3 years (13 patients)	3	5	2	2	4
3 - 5 years (13 patients)	4	3	4	2	4
5 - 8 years (7 patients)	2	2	2	1	3
Over 8 years (9 patients)	5	4			

In Table III-B we have recorded the length of hospitalization rather than the onset of psychosis because the latter could not always be definitely ascertained from the history. The actual duration is therefore in many cases considerably longer than is here indicated. Of the eighteen patients falling into the first three year period,



twelve (67%) showed some degree of improvement, five (28%) had remissions, and six (33%) left the hospital. The apparent discrepancy in the last two figures is due to the fact that one patient who exhibited slight improvement but no remission, was taken home by his family against our advice.

Of the twenty-nine patients who had been hospitalized for more than three years, eighteen (62%) showed some degree of improvement, nine (31%) had remissions, and seven (24%) went home. Compared with the first three-year period these last results seem to be highly significant, all the more so in view of the pessimism that most writers on the subject express for patients ill more than three years.

### III C. According to Sex

		No Change	Improved	Remission With Defect	Completer Remission	Home Parole
	No.	9	13	7	7	13
Male	Per cent	27%	35%	20%	20%	36%
	No.	7	4	0	0	0
Female	Per cent	63%	37%	0	0	0

Table III C should be compared with Table III A; it reveals that practically all of the good results were attained in the thirty-six male patients, none of the females showing remissions or leaving the hospital. The explanation for this unusual discrepancy has puzzled us considerably, but should perhaps be sought in factors other than any intrinsic differences in the nature of the psychosis in the two sexes. For example, the female patients in this series had a much longer average hospitalization than the males. Then, too, the treatment in the females had to be occasionally interrupted because of menstrual periods and other physical indispositions, as a result of which they necessarily received fewer injections and at longer intervals. From the evaluation of some of these factors, we have come to the conclusion that a course of metrazol therapy should consist of at least twenty grand mal paroxysms in schizophrenia and approximately half that number in manic-depressive psychosis, the injection to be repeated every other day, or, in some cases, every day.

Under such conditions one notes that 40% of the male patients had remissions, and 36% returned home. Altogether some degree of improvement was manifested in 63% of the men, as contrasted with only 37% of the women.

The question of relapse is rather difficult to evaluate at times. One must not regard daily or weekly fluctuations in behavior as constituting remissions or relapses, for such fluctuations are the rule rather than the exception during the active phase of metrazol therapy. For the sake of uniformity, we would therefore suggest that no apparent relapse be regarded as definite unless it has occurred after an arbitrary period of one month's continuous remission. Using this criterion, we find that only two of our patients have relapsed, one, after having been continuously at home for more than six months.

Of the thirteen patients who are now at home, all have been out of the hospital for more than six months, and of that number, six have been out for a year or more.

### III D. According to Hospital Status

	Employed	Ground Parole	Mute	Assaultive	Destructive	Untidy	Noisy
Before metrazol	12	5	7	10	11	12	7
After metrazol	35	19	5	3	4	3	2

In Table III D are summarized some of the results that are so important from a hospital viewpoint, yet have been so little stressed in the literature. Recently Cohen (14) devoted a paper to this subject. Among the most decisive changes seen in favorable cases is that having to do with the attitude towards work. Coincident with an externalization of interests, this desire for occupation is one of the earliest and most frequent evidences of improvement under metrazol therapy. Thus, one notes that nearly three times as many patients were able to work, and four times as many to enjoy ground parole after treatment than before. Other troublesome symptoms that were benefited, in order of frequency, were: untidiness, assaultiveness, destructiveness, noisiness. Mutism, alone, contrary to our expectations, failed to show any significant yield. Of course, in our patients this was usually the

chronic mutism of deterioration; one gathers the impression from the literature that the acute mutism of a recent catatonic stupor or depression clears up rather promptly.

In closing this section of our paper, a few random observations may be of interest. We have noticed that, from a prognostic viewpoint, the degree of deterioration is more important than the duration of the psychosis — most remissions occurring in patients with slight deterioration. The degree of reactivity to metrazol does not seem to be of prognostic value, nor does the gain in weight. Immaterial also to prognosis is the presence or absence of a fear reaction during treatment. Neither the patient's weight nor his degree of deterioration has any apparent relation to his convulsive threshold; however, manic-depressives and patients with an alcoholic background seem to have a relatively high threshold.

In our experience, the only complications worth mentioning were the occurrence of dislocations of the jaw in two patients and a dislocated shoulder in another patient; these were promptly reduced without any residual disability.\* We have been quite surprised to note the large incidence of dislocated jaws reported in the literature, some writers even going so far as to state that these are the rule rather than the exception. We would suggest as an explanation of this discrepancy that the majority of these "dislocations" are merely apparent ones, due to the wide opening of the mouth so characteristic of the tonic yawn that initiates the convulsion — and that if left alone, the jaws will usually come together spontaneously at the end of the paroxysm.

### Theory of Action

As we have pointed out before, a more comprehensive theory is required to explain the effect of shock therapy than has been hitherto suggested. Not only has the theory of biological antagonism between epilepsy and schizophrenia failed to explain the success of metrazol therapy in psychoses other than schizophrenia, but there is increasing evidence that the supposed antagonism does not even exist. For example, Lewis (15) in a comprehensive survey of the literature states that the clinical combination of epilepsy and dementia praecox appears quite frequently in large mental hospitals. Like-

wise, Jelliffe and White (16) state in their text book that many cases of so-called epilepsy prove, on prolonged observation, to be cases of dementia praecox with convulsive manifestations. Recently, too, Gibbs and his co-workers (17) have shown that the electro-encephalogram obtained in epileptic patients having psychomotor seizures is surprisingly similar to that seen in most schizophrenic patients; these investigators arrive at the significant conclusion that any relationship between epilepsy and schizophrenia is *positive* rather than negative.

It seems to us not only logical but also important to seek an underlying factor common to *all* forms of pharmacological "shock" therapy rather than to endow each form with a unique theory applicable only to itself. Fortunately such a factor is present as has been convincingly demonstrated by Gellhorn (18) in an important paper recently. Citing not only his own experiments but also the work of numerous other investigators, Gellhorn has proved that this common factor is cerebral anoxia, it being an accompaniment of insulin shock, metrazol convulsions, carbon dioxide inhalation and prolonged narcosis. Having established this underlying relationship, however, his subsequent conclusions seem too limited in their scope, for he believes that the anoxia itself is incidental, the chief mechanism of cure being the reflex stimulation of the sympathetic nervous system that it produces. He confines his observations to schizophrenia, and bases his belief upon the fact that the function of the sympathetic system is admittedly deficient in that disease. Unfortunately, however, this theory is again inadequate to explain the therapeutic mechanism in non-schizophrenic psychoses where there may be no deficiency of sympathetic tonus.

We believe, therefore, that the cerebral anoxia is the principal mechanism involved, and that, rather than playing a subordinate role, it exerts a direct effect upon cerebration itself, either by producing a shift of the chemical equilibria of the cortical cells, or else by a specific destructive action upon certain of the cells, the result in either case producing an alteration of the physiology of cerebration.

The following analogy may serve to clarify the problem. We know that the more embryonic a structure, the more susceptible it is to inquiry.

\*Much controversy has been caused by the recent reports of Polatin and his co-workers (J.A.M.A. 112:1684, Apr. 29, 1939) and Bennett and Fitzpatrick (J.A.M.A. 112:2240, June 3, 1939) on the high incidence of vertebral compression fractures following metrazol convulsions, often with surprisingly minor subjective symptoms from the patients themselves. It is to be hoped that further investigation and experience may find some means of overcoming this serious complication.



This principle forms the basis for the irradiation therapy of neoplasms; the rays, applied within therapeutic limits, destroy the neoplastic tissue without profoundly affecting the older, normal tissue surrounding it. If this is true of structure, may it not also be true of function? To answer this, we may think of the psychotic pattern as consisting, like the neoplastic structure, of primitive, undifferentiated, embryonal material — a concept that finds its counterpart in the well-known theory of infantile regression in the psychoses. With that analogy in mind, it seems reasonable to assume that if the psychotic mind is subjected to a controlled, destructive action like that of pharmacological shock, the more recent association pathways which form the pattern of the psychosis will be the first affected, leaving the older, pre-psychotic pattern relatively intact.\*

This theory not only establishes a fundamental relationship between the various methods of treatment, but also has its practical counterparts. For example, it is well known that a cerebral shock of any kind is apt to produce a temporary amnesia for recent events. This is true not only of the methods mentioned above, but also of traumatic shock, febrile delirium, and surgical anesthesia. Psychiatrists are familiar with the improvement that sometimes follows those states in a psychotic patient. Why — unless it be true that *recent* memory patterns are more unstable, less firmly fixed, hence, first to be affected by a cerebral insult. And in organic disease, also, one may note this tendency for loss of recent memory, best typified in senile dementia, where the pathophysiological alteration of psychic processes expresses itself first in a loss of the more recently acquired mnemonic patterns, leaving the older ones relatively intact.

This tendency for the destruction of new association pathways is especially noticeable following metrazol therapy, many investigators having been impressed with the amnesia for recent memory that sometimes accompanies a remission; in these cases the destructive effect of the convulsions upon the psychotic pattern has apparently encroached to a greater or lesser extent upon the normal pattern as well. Recently two interesting papers have appeared, one by Canseco (19) and the other by Plattner (20) on amnesic phenomena resulting from shock therapy.

## Summary and Conclusions

1. Metrazol has a limited but valuable place in the present-day treatment of long-standing functional psychoses. It should no longer be confined to the treatment of schizophrenia, but should also be used in manic-depressive and other types of functional mental disorders.

2. In a group of 47 patients with an average age of 31 years and an average hospitalization period of three and one-half years, various degrees of improvement were obtained in 62% of the cases. Apparent remissions occurred in 32%. Thirteen patients, or 28% of the total were able to return home; six of these have been home for more than a year, and all, for more than six months. Of the 29 patients who had been hospitalised for more than 3 years, 62% showed some degree of improvement, 31% had remissions and 24% went home. We have concluded that the degree of deterioration is more important than the length of hospitalization as far as the prognosis to treatment is concerned.

3. From a hospital viewpoint, the value of convulsant therapy in alleviating various disturbing symptoms is important even in those cases where actual remission is not to be expected.

4. The successful treatment by metiazol convulsions of an attack of acute delirious excitement, of the type formerly known as Bell's mania, is here reported for the first time.

5. The following theory is offered to explain the underlying principles of the action of modern "shock" therapy in the various psychoses: Pharmacological shock therapy induces a temporary cerebral anoxia, the intensity of which depends upon the duration, profundity, and repetition of the shock. Within therapeutic limits, the destructive effect of this anoxia upon the ganglion cells produces a selective alteration of the comparatively recent, undifferentiated psychotic association pathways, leaving the older pre-psychotic mnemonic pattern relatively intact. This theory suggests that it might be worthwhile to investigate the effects of various other asphyxial agents, such as the inert gases or anesthetic gases, in the treatment of mental disorders.

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\*That metrazol convulsions may actually cause destruction of ganglion within certain limits has recently been called to our attention by H. M. Zimmerman in a personal communication. F. Accornero, in an article which reached us after this paper was submitted advances practically the same theory as ours ("Histopathology of the Central Nervous System in Insulin Shock: Experimental Contribution to the Knowledge of the Mechanism of Action in Insulin Shock Therapy." — *Riv. di Pat. Nerv. e Ment.* 53:1, Jan. — Feo. 1939). He also describes ganglion-cell destruction through insulin shock, but believes that the loss of a certain number of neurones from among the immense number found in the cortex may not give rise to appreciable mental defect, and that the neurones lost are among the most labile, namely those of most recent phylogenetic and ontogenetic development. He also sees certain analogies between such alterations and the "leucotomia" method of surgical intervention in the cortex by Moniz.



## Localization of Pain in Back Injuries\*

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The use of procaine in localizing pain has been well established. In back injuries, whether confined to soft parts or to bony structures, pain is the greatest disabling factor. Often this pain appears to be out of all proportion to the actual injury. All too frequently it disconcerts the physician and prevents him from making an accurate diagnosis. Acute injuries almost always have definitely localized areas of tenderness. Old injuries and chronic diseases involving the back may show, on the other hand, large indefinite areas of tenderness. Because of this fact, acute injuries lend themselves more readily to this particular manner of approach.

The technic of localizing back pain is relatively simple. Following a general examination which should enable the examiner to more or less approximate the site of injury, the patient is placed flat on his face with a pillow under his abdomen for relaxation. The whole lower dorsal, lumbar and gluteal area is shaved and prepared with iodine and alcohol. The examiner, wearing sterile gloves, then elicits all tender points and marks these areas using a swab impregnated with a dye. Several wheals are raised with 2% procaine hydrochloride over the tender areas. A long, thin, sharply beveled needle is then introduced through each wheal and the point allowed to penetrate the various structures encountered. With an accurate knowledge of anatomy, the various parts can thus be tested with the needle point and when the one injured is encountered, there will be an acute increase of the same pain described by the injured patient. Steindler calls this the "trigger point." Kellgren of London injects very small amounts of normal saline into the tender areas or structures to elicit "trigger points". He follows it up with 1% novocaine infiltration which, according to his report, completely abolishes pain, particularly if arising in a strained muscle or fascial attachment.

Steindler of Iowa City and Haggard of Boston, as well as a host of others, use this method

even for sciatic neuralgia. Digliotti, a Frenchman, and Farr, an American, were the first to use this method in a variety of soft parts injuries of the back. Leriche, probably the most outstanding surgeon of France today, has used injections of novocaine in the treatment of sprains of the extremities for many years. He believes that the anesthesia suppresses nervous irritability of the strained ligaments, allows an immediate restoration of normal function of parts affected, with healing taking place more rapidly.

By this localizing technic, a strained inter-spinous ligament, a torn fascial attachment, a fractured transverse process, a strained posterior ilio-sacral ligament or an injury about the intervertebral articular capsule is readily detected. If seen early, pain from an aggravation of a pre-existing hypertrophic arthritis can be demonstrated. Into the site, so delineated, is then injected from 2 to 20cc. of the solution. If the injured parts have been thus accurately blocked off, the pain disappears. If it does not disappear a second attempt must be made in the same manner to localize the pain. If the second attempt is unsuccessful, an epidural injection is performed with a long needle entering the sacral hiatus, introducing 10 cc. of procaine followed by 50-150 cc. of normal saline. The volume of saline used depends upon the level of pain. Less is used the nearer the tender area approaches the lumbosacral junction. This should always reduce the pain. In case the injury involves the intervertebral disc, the ligamentum flavum, the anterior iliosacral ligaments or any other part that cannot be reached by the testing needle point, an epidural injection should alone cause the pain to diminish, if not disappear. Incidentally, the patient seems to experience some permanent relief. Just why this is so the author is unable to explain unless Leriche's theory is applicable. It is well, though perhaps obvious, to urge caution and to suggest a sensitization test so that a novocaine reaction can be prevented, or at least controlled.

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For many years manipulation of back injuries has been advocated by both regular and irregular practitioners. The use of an anesthetic generally indicated the practitioner's regularity. Thus the use of procaine, inducing at least temporary anesthesia, enables one to passively manipulate the back or, better still, to permit the patient to actively and much more effectively manipulate his own back. This calls for the use of traction either by pulling on the upper and lower extremities or by having the patient hang from a high overhead bar. Rotation of the trunk on the pelvis can be performed. It is not difficult to imagine how such manipulations aid in repositioning the structures and so prevent the recurrence of muscle spasm when the anesthetic effect has worn away.

Although this procedure has been used during the past three years in several hundred instances, the author does not claim any originality and is not prepared to propose it as a form of treatment but offers it as a very effective procedure in a differential diagnosis and localization of pain in back injuries.

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#### SILK INSTEAD OF CATGUT

How the use of silk, instead of catgut, in closing surgical wounds has made the after-operation period much easier for the patient and reduced the hospitalization period was described by Dr. Donald Guthrie, Sayre, Pennsylvania, surgeon, who was guest speaker of the 133rd annual meeting of the Medical Society of the State of New York. Dr. Guthrie said in part:

"Using the silk technic, wounds have been uniformly closed without drainage, serum accumulations have been infrequent, and no infections have developed. Hospitalization periods have been reduced four to six days."

He said that when catgut was formerly used in appendectomy, the hospitalization period was usually nine days, whereas, using silk, the patient was up in four days and went home in seven days.

*N. Y. State Jour. Med.*, June 1, 1939



#### MATERNAL AND INFANT MORTALITY IN MISSOURI AND NEW JERSEY

The maternal mortality rate for Missouri in 1937 was 5.13, the infant mortality rate, 64.01, both above the average for the country at large where the rates were 4.9 and 54.4, respectively. The factors responsible for these high rates in Missouri, according to the March issue of the *Journal of the Missouri State Medical Association*, are the low income groups living in densely populated areas and the groups in densely populated areas and without adequate medical care.

New Jersey found its maternal mortality rate for 1938 — 35 per ten thousand live births — higher than for 1937. The number of deaths from puerperal sepsis increased 16 per cent. The number of deaths from puerperal hemorrhage increased 62 per cent. The number of deaths from ectopic gestation increased 62 per cent. In 35 per cent of the maternal deaths there was no prenatal care, according to the *Journal of the Medical Society of New Jersey* for April, 1939.

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# The Present Status of the Supraventricular Tachycardias: Their Diagnosis and Treatment

EDWARD GIPSTEIN, M.D., New London, Conn.

## The Normal Heart Beat

The study of the supraventricular tachycardias is both an interesting and fascinating subject. A clear conception of the different types, their diagnosis and treatment is very essential. The appreciation of the mechanism present, and the necessity of employing emergency measures to ward off an impending catastrophe are all too apparent. True, the tachycardia may be benign and disappear after a few minutes but not infrequently, when the rapid heart rate has persisted for several hours, congestive heart failure has resulted. In order to understand the pathological mechanisms, it is not amiss to briefly review the origin and course of the normal heart beat.

By supraventricular tachycardia we mean a rapid heart rate whose impulse is initiated above the ventricles. The impulse<sup>1</sup> that initiates the normal heart beat arises at the sino-auricular node or the node of Keith-Flack, a specialized collection of nerve fibers and ganglia cells, situated at the junction of the superior vena cava and the right auricle. This node is known as the pace-maker of the heart. From here the impulse spreads to the auricular muscle which undergoes contraction. It then reaches the junctional tissue between the auricles and ventricles, the auriculo-ventricular node or node of Tawara, situated at the posterior portion of the auriculo-ventricular septum just at the point where the coronary vein empties into the right auricle. From here the impulse passes forward to the inter-auricular septum where the Bundle of His is located and which at the top of the inter-ventricular septum divides into two branches, the right and left bundles, extending down each side of the ventricular septum. The path continues to the Purkinje fibers and spreads throughout the two ventricles.

## Extrinsic Nervous Mechanism<sup>2</sup>

The sino-auricular node is under the influence

of the extrinsic nervous mechanism, the vagus and the sympathetic. The right vagus controls chiefly the S-A node while a few strands go to the A-V node. The left vagus controls chiefly the A-V node with a few strands extending to the S-A node. The sympathetic fibers affect both nodes. The vagus fibers are linked to a structure at the carotid artery and is known as the Carotid Sinus. If the Carotid Sinus is compressed then the vagus nerve is influenced indirectly and through it the S-A node. Hence, pressure on the right Carotid Sinus will slow the heart more readily than pressure on the left, as the greatest number of right vagus fibers influence the S-A node.

## Associated Conditions<sup>2</sup>

The conditions associated with the supraventricular tachycardias can be divided into those due to extrinsic factors and those due to disease.

<i>Extrinsic Factors</i>	<i>Disease</i>
1. Fatigue and Exertion	A. Non-Infectious
2. Drugs (Digitalis, Adrenalin, Atropine)	a. Rheumatic Heart Disease
3. Anesthesia	b. Arteriosclerotic Heart Disease
4. Cerebral Stimulation	c. Graves' Disease
5. Profound Asphyxial States	B. Infectious
6. Trauma	a. Diphtheria
7. Chest and Spine Deformities	b. Typhoid Fever
8. Lung Involvement	
9. Gastric Disturbances	
10. Uremia	

## Types

Sinus tachycardia, paroxysmal auricular tachycardia, nodal tachycardia, auricular fibrillation and auricular flutter comprise the supraventricular tachycardias. All these types, with the exception of sinus tachycardia, are ectopic rhythms; that is the initiation of the heart beat does not take place in the S-A node, but in some

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ectopic focus either in the auricular muscle or in the A-V node.

Sinus Tachycardia is a condition in which there is an acceleration of the heart rate, the impulse of which starts in a normal focus, the S-A node. The rate may reach 170 beats per minute, and the rythm is regular. The rapid rate does not either begin nor end abruptly but pursues a gradual course.

Paroxysmal Auricular Tachycardia may be defined as a series of rapidly recurring extrasystoles which completely submerge the physiological rhythm<sup>6</sup>. It is a rapid regular rhythm the impulse of which is initiated in an ectopic focus in the auricular musculature other than the S-A node. The rate may vary from 150 to 250 beats per minute. The paroxysm begins and ends abruptly and, clinically, is suspected when there is a rapid regular rhythm that is unaffected by position, rest or exercise. The duration of the attack varies from several minutes to even several days. It is a very common condition in individuals that have no organic heart disease and may appear after a heavy meal, sudden turning of the head, violent exercise, emotional disturbances or inhalation of tobacco smoke. The chief symptom is palpitation, although at times there is actual chest pain. When the attack has persisted for any length of time the patient may become agitated and apprehensive. Peripheral thromboses, congestive heart failure, hemiplegia, aphasia and dry gangrene of an extremity have been reported<sup>1</sup> during some attacks, altho these complications are not at all common.

Auricular Flutter is produced by the passage of the impulse over one or more circular pathways—a circus movement. The auricles contract regularly usually at a rate of 200 to 350 beats per minute and the ventricles beat regularly at a rate  $\frac{1}{2}$ ,  $\frac{1}{3}$ , or  $\frac{1}{4}$  of the auricular rate. Occasionally the ventricles may beat irregularly, a so-called impure flutter. In flutter there is a relative heart block present as not all the auricular impulses can reach the ventricles. Rarely, the auricular and ventricular rates may be the same, a 1 to 1 flutter. The symptoms are chiefly palpitation and chest pain, and it usually accompanies grave heart disease.

Auricular Fibrillation is a condition in which there is no contraction of the auricular muscle as

a whole, but in which different fibers of the musculature fibrillate, the rate of the fibrillation being from 350 to 500 times per minute. The ventricles contract irregularly as the impulses from the auricles reach the ventricles haphazardly. A relative heart block is present. The ventricular rate is from 90 to 160 beats per minute and a pulse deficit is usually present. With toxic doses of digitalis a rapid regular rhythm may be established. Auricular fibrillation may be transient or permanent. This grossly irregular rhythm is present frequently with mitral stenosis, hypertensive heart disease, with some cases of acute rheumatic fever, during acute coronary thrombosis and hyperthyroidism<sup>1</sup>. It has been reported in association with acute angioneurotic edema, chronic gall bladder disease and during general anesthesia. The most common symptoms of this irregularity are palpitation, dyspnoea and chest pain. The chief complication is the formation of emboli.

Nodal Tachycardia is the condition produced by the impulse of the heart beat arising in the auriculo-ventricular node instead of in the S-A node. The rate is usually over 100 and the rhythm in most cases regular. It has no clinical significance and can only be diagnosed with the aid of the electrocardiogram<sup>3</sup>.

Diagnosis  
At The Bedside

	<i>Rhythm</i>	<i>Rate</i>	<i>Exercise</i>	<i>Carotid Si- nus Pres- sure</i>
Sinus Tachy- cardia:	Regular	100-150	Increases Rate	Tempor- arily slows the heart - Then re- turns to ra- pid rate.
Paroxysmal Auric. Tachycardia:				
	Regular	150-250	No Effect	Remains unaltered or abruptly falls to nor- mal.
Nodal Tachycardia:	Not Diagnosed at Bedside			
Auricular Flutter:	Usually Reg.	V. $\frac{1}{2}$ , $\frac{1}{3}$ $\frac{1}{4}$ A. Rate (A. 200- 350)	No Effect	Tempor- arily slowed — Then re- turns to rapid rate.

**Auricular Fibrillation:**

Grossly Ir- V. 90-160 Increases No Effect  
regular (A. 350- the Irre-  
500) gularity

Differentiated from numerous ex-  
trasystoles by listening at apex  
of heart (1).

In Auric. Fib. a sudden pause  
will be heard not preceded by a  
quick beat.

**Ventricular Tachycardia:**

Slightly Ir- 160-180 No Effect No Effect  
regular

When listening at apex of heart  
there is slightly irregular rhythm  
and difference in intensity and  
quality of first heart sound<sup>1</sup>.

**Electrocardiogram**

Sinus Tachycardia: 1. Rapid rate-Regular Rhythm.  
2. Normal Complexes.  
3. T-P interval shorter than nor-  
mal.

Paroxysmal Auricular 1. Rapid rare-Regular rhythm.  
Tachycardia: 2. P waves usually fused with pre-  
ceding ventricular complex. Both  
may be of abnormal shape.

Nodal Tachycardia: 1. P wave inverted or deformed  
and present before, during or after  
ventricular complex.  
2. Ventricular complex normal or  
aberrant.  
3. P-R interval short and under  
0.08 sec. usually.  
4. Rate over 100-Rhythm usually  
regular.

Auricular Flutter: 1. Auricles contract regularly.  
2. In lead 1 auricular waves small  
notches. In leads 2 and 3 there  
is a sharp up stroke and the down  
stroke is more prolonged and  
notched at mid-point.  
3. Ventricular rate usually regular  
and  $\frac{1}{2}$ ,  $\frac{1}{3}$ , or  $\frac{1}{4}$  auricular rate.  
Rarely the same rate as auricles.

Auricular Fibrillation: 1. No P waves, just fibrillatory  
waves.  
2. Irregular ventricular rhythm.

Ventricular Tachy- 1. Rapid succession of ventricular  
cardia: complexes having characteristics  
of premature ventricular con-  
tractions.  
2. P waves buried in the ventri-  
cular complexes.  
3. Slightly irregular rhythm.

**Treatment**

Quite frequently a patient is seen in whom a tachycardia has persisted for several hours, and in whom the condition might be such as to require immediate treatment. While in most cases the type of supraventricular tachycardia can be discerned at the bedside and the specific treatment given, there are a certain number of cases that appear quite puzzling, so much so that the condition cannot be differentiated without the aid of the electrocardiogram. Since this study is not often readily available, we must be prepared to act without its' aid. We are usually able to decide at the bedside whether or not the case is one of supraventricular tachycardia or ventricular tachycardia by remembering that the latter is quite rare, has a slightly irregular rhythm, with a rate around 170, and is not affected by exercise or by Carotid Sinus pressure. Furthermore, there is usually a difference in the intensity and quality of the first heart sound at the apex. Thus, having established the tachycardia as supraventricular in origin and recalling that all supraventricular tachycardias have their impulse initiated in either the auricular muscle, the S-A node or in the A-V node, we can follow a plan of treatment that will apply satisfactorily for the entire group. This procedure is tabulated as follows<sup>2</sup>:

A. If no medication has been given previously:

1. Carotid Sinus Pressure. For 1 or 2 minutes. One side at a time, usually right.
2. Ocular Pressure.  
Firm steady pressure for a few minutes.
3. Induction of Vomiting
  - a. Place finger down throat
  - b. Syrup of ipecac 1-4 drams
  - c. Soap water
4. Deep inspiration and holding breath
5. Large dose of digitalis  
1½ minims per lb. body weight of the tincture, given in warm water by rectum. Cleansing enema before drug is given. Use baby syringe. Same dose if given by mouth but

add some essence of peppermint to disguise the taste.

B. If patient has had medication (digitalis) and still has the tachycardia:

1. Quinidine sulfate grains 3 b.i.d. as a test dose. Watch for nausea, ringing in ears, diarrhea, skin eruption and disturbed vision. If these toxic effects do not occur then give quinidine sulfate grains 3 every hour day and night, taking heart rate every 15 minutes until mechanism returns to normal.
2. If toxic symptoms result from the test dose of quinidine sulfate, then give quinine dihydrochloride grains  $7\frac{1}{2}$  intravenously.
3. If no response from the quinine dihydrochloride then give 70 grains of quinidine sulfate in 500 cc. normal saline intravenously 40 drops per minute.
4. If no response from above mecholyl 10 milligrams subcutaneously. (Have atropine and adrenalin ready if untoward results should occur).
5. Finally oxygen might be used as a last resort, as it will temporarily slow the heart.

C. Prevention of Tachycardia:

1. Digitalis pill grains  $1\frac{1}{2}$  once or twice a day or
2. Quinidine sulfate grains 3 daily

If the particular type of supraventricular can be discerned, then it is not necessary to follow the above procedure, but to treat the specific condition. Briefly, we proceed as follows:

1. Sinus Tachycardia:  
No specific treatment. Removal of the cause returns the heart rate to its normal level.
2. Paroxysmal Auricular Tachycardia:  
Carotid Sinus Pressure, Ocular Pressure, Induction of Vomiting, Digitalis, Quini-

dine Sulfate or Quinine Dihydrochloride, Mecholyl, Oxygen. In some cases morphia may be given.

3. Nodal Tachycardia:

Same as for Paroxysmal Auricular Tachycardia.

4. Auricular Flutter:

- a. Digitalis in sufficient dosage to slow the ventricular rate. Condition usually changed to Auricular Fibrillation and if drug is then omitted a normal mechanism frequently follows. Repeated electrocardiograms may be necessary.
- b. Quinidine Sulfate grains 5 to grains 10 t.i.d. usually restores rhythm to normal.

5. Auricular Fibrillation:

- a. Digitalis in sufficient dosage to slow the ventricular rate to 60 or 70 beats per minute<sup>7</sup>, and then enough digitalis to keep it at this rate. Occasionally one large dose is given, repeated in several hours and again on the following day.
- b. Quinidine Sulfate grains 5 or grains 10 t.i.d.

6. Ventricular Tachycardia:

- a. Never use digitalis<sup>7</sup>.
- b. Quinidine sulfate in doses ranging from grains 5 t.i.d. to grains 22, 5 times a day.

### Comment

A general review and outline of the supraventricular tachycardias has been undertaken. It is hoped that the brief individual description, the associated conditions, the diagnostic approach and treatment of the group as a whole will be of some interest and practical value to the physician.

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(Continued on Page 385)



## 350 Cases of Scarlet Fever Treated with Sulphanilamide and Neoprontosil

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Hartford, Connecticut

In reporting this series of scarlet fever cases, we have tried to evaluate the use of sulphanilamide therapy in lessening the number of complications. We did not study the usual concurrent series of control cases, but the cases reported, compared similarly in severity with those noted over a period of ten years at this institution\*. In addition, the 350 cases reported comprise all the consecutive cases admitted over a period of three years, which we believe quite ample in overriding possible variations in severity and complications.

In a group of cases previously reported by us (1) during the scarlatinal anti-toxin era, an effort was made by us to specify the expectancy of complications of scarlet fever based upon the phases of the scarlatinal beta-hemolytic streptococcus\*\*. Our conclusions at the time were that one could expect in the locality of Hartford County approximately one septic case in every four and one-half consecutive cases; i.e., an incidence of 22.2% septic complications. Further, one could expect one allergic case in every two cases receiving scarlatinal anti-toxin, but only one allergic case in every three cases not receiving scarlatinal anti-toxin. In reviewing approximately 1000 non-serum cases at the time we found an incidence of 24.5% septic complications. Compare this figure with that given above (22.2%) and one can see a definite decrease in septic complications (2.3%). Finally there was a mortality of 3.7% in the non-serum cases and 1% in the serum cases, an apparent decrease in mortality of 2.7% with the use of

serum. However, with the administration of serum the incidence of cervical adenitis has definitely increased. This increase must consequently be dependent upon serum reaction.

The sex and age distribution of our present series were as follows: 174 patients were males and 176 were females; 13 were colored, the remainder, white.

1 to 2 years —	1 case
2 to 3 years —	13 cases
3 to 5 years —	58 cases
6 to 10 years —	148 cases
11 to 15 years —	68 cases
16 to 20 years —	26 cases
21 to 30 years —	21 cases
over 30 years —	15 cases

The youngest patient was 20 months while the oldest patient was 54 years of age. 288 or 82.2% were below the age of 16.

The average duration of illness previous to hospital admission was 2.25 days.

The average number of febrile days among those under treatment was 2.7. In this series, we considered febrile days those wherein rectal temperatures above 100° were recorded.

The average duration of the rash was 4.07 days.

The average duration of the therapy was 7.7 days, varying from 4 to 14 days. The usual dosage followed that advocated by various previous observers (2). For patients to 2 years of age we used 1¼ grains per pound of body weight, from 2 years and over 1 grain per pound of body weight, up to a maximum of 90 grains per day.

\*Hartford Municipal Hospital — Division of Communicable Diseases.

\*\*In explanation of the complications: the group under which each complication was placed was determined by the phases of the streptococcus scarlatinae.

1. Toxic phase: Rash, myocarditis, meningismus.

2. Septic or pyogenic phase: Bronchopneumonia, pleurisy, empyema, lung abscess, sinusitis, exudative pharyngitis, peritonsillar abscess, otitis media, mastoiditis, labyrinthitis, sinus thrombosis, brain abscess, meningitis, stomatitis, endocarditis, pericarditis, pyelitis, suppurative adenitis, suppurative arthritis, peritonitis, septicemia, bacteremia, etc.

3. Allergic phase: Simple adenitis, myalgia, arthralgia, late skin rashes, glomerular nephritis, rheumatism, and simple arthritis.

We are not attempting to build up unquestionable clear-cut phases of the scarlatinal beta-hemolytic streptococcus since the above sequelae frequently overlap.

The patients received their maximum dose for 24 hours, this dose then being reduced over a period of 3 days to a maintenance dose of one-half of the original daily dosage for a further period of 4 days. It is interesting to observe that the average duration of therapy in our group was 7.7 days,  $4\frac{1}{2}$  days longer than was reported in some of the other series of cases where it was given only during the febrile stage (3). We feel that our success was due for the most to this procedure. This is borne out not alone by our cases, but also by the Sako, Dwan, Plateau series (4). We also know that some of the mild cases herein reported would have done as well without any therapy.

Of the 350 cases, 30 were admitted with complications already present. 13 or 3.7% entered with otitis media, and 17, i.e. 4.8%, with cervical adenitis.

The complications which developed following treatment with sulphanilamide and neoprontosil (oral therapy) in the 320 remaining cases were as follows:

acute cervical adenitis	20
acute suppurative otitis media	7
acute cervical adenitis & acute nephritis	1
acute nephritis	2
*non-septic hip	1

The above figures reveal a total of 9.7% who developed complications. Approximately one-quarter, 2.18%, of these were septic in nature and three-quarters, 7.5%, allergic or toxic. It is our opinion that these complications might have been further reduced in number if earlier treatment of adequate dosage could have been administered.

There was no mortality in this group, as compared with our previous average mortality of 2.3% in the combined serum and non-serum treated cases (1).

Compare likewise the above mentioned total of 2.18% septic complications, a reduction of about 20% as against 22.2% septic complications with anti-toxin treated cases (1). Our present series of cases shows only 2.18% acute suppurative otitis media as contrasted with 6% in the Schwentker and Waghelstein (5) groups, and 11% in the Peters and Havard group (6).

Our group has not shown all the toxic accompaniments, commonly reported with sulphanilamide usage. We have not observed acidosis, renal involvement, jaundice or marked hemolytic anemias. We have, however, noted cyanosis in 92%, simple fever in 8%, a mild hemolytic anemia in 52% (which may be due in part to the streptococcal infection). Cerebral toxic effects were noted in 15%, dizziness, nausea, vomiting and anorexia of varying degree were seen in 78% and dermatitis in 3%. Multiple sequelae were observed in the same patient. We interpret cerebral toxic effects to include disorientation, hyperexcitability and listlessness. These latter symptoms may be described as simulating various phases of alcoholic intoxication. Two of our cases showed extreme hyperexcitability and disorientation to the extent that they could be restrained only with difficulty. Both were adult males, who received rather large doses of the drug. Another patient presented abdominal signs resembling a perforation of a hollow viscus, with a generalized peritonitis, while still another presented all the signs of meningeal irritation (meningismus). We have also observed occasional epistaxis with the use of the drug. Whether or not this was secondary to the disease or the drug could not be definitely determined.

It is interesting to note that a certain number of individuals develop an allergy to sulfanilamide and we feel that the usage of the drug will become limited in this type of patient unless the sensitivity can be alleviated. We have frequently observed allergy when this drug was administered in patients who had previously received it. In these cases an immediate rise in temperature with or without an increase in cyanosis was noted. However, upon withdrawal of the drug all symptoms usually disappear.

Recently we have substituted neoprontosil orally for sulphanilamide. The advantage lies in its lesser toxicity without reduction in therapeutic value\*\*. In approximately 60 cases thus far treated with neo-prontosil we have observed few anemias, while cyanosis, rash, diarrhea and disorientation were rare. This drug is of further value in those cases where debility due to toxemia, or where persistent emesis prevent oral

\*Serous synovitis; operation revealed no pus, and culture of the joint was negative for beta-hemolytic streptococci.

\*\*The use of neo-prontosil because of the fewer side effects lessens the eternal vigilance attendant upon home administration of sulphanilamide.



administration of medication. We have observed a slight increase in the incidence of cervical adenitis over the sulphanilamide group. We have found rectal administration in the form of a suppository consisting of the required amount of neo-prontosil (powdered) in cocoa-butter to be satisfactory\*\*. Occasional expulsion of the suppository in the very young may be overcome by holding the buttocks together tightly for ten minutes after its introduction so that liquefaction may occur.

Subsequent comparative blood and urine studies revealed that the concentration of sulphanilamide achieved by the rectal administration of neo-prontosil equalled that of the oral\*. The figures below represent the maintenance blood and urine levels on four representative cases achieved after the third day with rectal neo-prontosil.

We have reserved the use of scarlatinal antitoxin for those cases where sulphanilamide is contraindicated. To this group we have relegated particularly those cases showing nephritis, untoward reactions or failure to improve with the drug. Of course, we must remember that with the use of sulphanilamide, the unpleasant serum reaction, which may sometimes be worse than the disease itself is avoided.

It is our contention that early administration of sulphanilamide or neoprontosil is indicated as a prophylactic measure against septic complications. We have found that the drug has little effect against a process which has already supplicated; improvement does not ensue until the pus is evacuated. Consequently we believe that its value is chiefly a prophylactic one (bacteriostatic) as proven by the reduction in septic complications.

Recently we have used a sterile 2% neo-prontosil solution with rapid drying effects in some cases, as a form of aural irrigation in suppurative

otitis media. We recommend thorough dry cleaning of the ear immediately before irrigation. However, additional cases are necessary for definite information concerning the value of this form of treatment over any form of irrigation therapy.

Throughout this series, we have followed the practice advised in our previous article of giving meat and egg to our scarlet fever patients toward the end of the first week of hospitalization without noting any untoward effects.

### Summary

1. 350 cases of scarlet fever treated with sulphanilamide and neo-prontosil are reported. There was no mortality in this group. The cases were similar in severity to those reported in a previous paper. The total number of complications was 31 or 9.7%. One quarter of this group, 2.18%, was classified as septic, and three quarters, 7.5%, as allergic or toxic complications. The present series showed a reduction in the grand incidence of septic sequelae from 22.2% (1) to 2.18% or an improvement of about 20%. We believe that earlier treatment could have further reduced the number of septic complications. The number of febrile days was shortened. We believe further that the period of quarantine could be shortened if the local presence (nose and throat) of the beta-hemolytic streptococcus could be controlled. (A rapid method of differentiation between the scarlatinal beta-hemolytic streptococcus and the non-scarlatinal streptococcus would be welcome because the latter is so frequently found in apparently normal throats.)

2. The usual untoward side-effects of sulphanilamide described many times elsewhere were observed with few exceptions, but these

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Urines	Case 1	Case 2	Case 3	Case 4
Total sulphanilamide . . . . .	96 mgms. †	68 mgms.	67.5 mgms.	58.5 mgms.
Free form . . . . .	31.2 mgms.	20.1 mgms.	25.8 mgms.	33.2 mgms.
Conjugated form . . . . .	64.8 mgms.	47.9 mgms.	47.7 mgms.	25.3 mgms.
Blood				
Total sulphanilamide . . . . .	3.1 mgms.	2.2 mgms.	2.1 mgms.	1.7 mgms.
Free form . . . . .	1.9 mgms.	1.6 mgms.	1.5 mgms.	1.2 mgms.

†Milligrams per 100cc. of urine or blood.

\*Lubricating the neoprontosil suppository with an anesthetic ointment allays possible rectal irritation.

\*\*Blood and urine investigations done by Dr. Perry T. Hough.



## Address by His Excellency, Raymond Baldwin, Governor of the State of Connecticut\*

Medicine rapidly is becoming — if it has not already become — the last rallying point of this thing that we call "Our Civilization." Once we said "Art," "Religion," "Music," "Literature" — yes, even "Science." *They* knew no race, no politics, no nationalism, we used to say. The artist, the minister of God, the musician, the great writers and scientists — *they* were for the world. Today, we see great books being burned, their authors exiled, because of racial hatreds. We see Art banished, great works of music forbidden. We see Science shackled, perverted, the greatest scientists driven out of their homelands. We see Religion, on the one hand trampled upon, persecuted, beaten down, or on the other hand used merely as a propaganda agency for some monstrous State. Only in Medicine does the world, apparently, still ride upon an even keel.

Very recently, there was held here in this country a meeting, as I understand it, of medical men, military medical men, from all of the countries of the world. Perhaps some of you gentlemen here tonight attended it. There were English and German, French, Japanese, Russian, Spanish and Italian, Scandinavian and South American — all were there — doctors and surgeons, dental men and specialists of every description. And the man who told me about that meeting said: "You know, Governor, it was the most amazing thing! No other such meeting could be held, would be possible, in the world today! There they all were, meeting together to exchange information, to help one another, to give one another the best of each other's experience and discoveries, freely, cooperatively, hopefully, *not* on the basis of race or nationality, but simply as *doctors*, medical men, whose duty it was to all humanity!" In what other field of human endeavor today would you discover that to be possible?

You medical men live today in a sick world. Our civilization is stricken unto death, afflicted by tumors and cancerous growths, its blood-

stream poisoned, its nervous system disarranged to a point where, perhaps, in some instances, a psychiatrist rather than a medical man would better be called in. Here in our country, probably because we are big and husky, we have succeeded (to date, at least) in throwing off infections from abroad. Oh, we are not immune, we have broken out in a rash here and there, and here or there we have come down with a fever of long or short duration. But we have not — not yet — come down, seriously, with any of these foreign ailments. Truth is, we have enough ailments of our own, right here, to contend with. If I were a doctor called in to attend Uncle Sam in this illness of his I think I should diagnose his case as fifty per cent — at least fifty per cent! — hypochondria. And the other fifty per cent I think I should blame on the "doctors," the "doctors" who have been attending him and prescribing for him. There's such a thing, is there not, as *too many* blood transfusions? — *too many* injections? As a matter of fact, even, I'm afraid the "doctor's" bed-side manner, in attending the patient, isn't all that it should be. The important thing, I'm told, is to instill confidence, confidence in the "doctor's" ability, and *self*-confidence in the patient himself.

We've got a sick man, here, an accident case. He was in a pretty bad crash. He broke a leg, *both* legs, and an arm or two, and a half dozen ribs, and suffered internal injuries besides, to say nothing of a nasty bump on the head. But the worst of it was shock. He was in considerable pain, too. A sedative was in order (I have no doubt of it); but you can't go on administering sedatives indefinitely. Besides, it's my private conviction that the broken bones are healed, long since healed.

What do you do with a patient recovering from a broken leg? Do you permit him to go on lying in bed with his leg in a cast *indefinitely*? Or do you say to him: "You must begin to *use* that leg as soon as you are able, else the muscles will become atrophied." I do not know how you

\*Abstract of address delivered at 147th Annual Meeting, New Haven, May 25-26, 1939.

doctors would do it, but I do know we must get our patient back onto his feet . . . Before much more serious complications set in than have yet developed. We can not ethically, much longer encourage a neurotic that looks hopefully to continued medication, artificial stimulents, indefinitely prolonged hospitalization. There are so many *other* things waiting to be done!

Government's job is to assist, collaborate, if you will, but *never* to take over. This I believe, that no person, man, woman, or child, in this land of ours should, through no fault of his own, because of unemployment, or inability to pay,—no man, woman or child should have to go without adequate medical care — *ever*!

Medicine itself, I think, has recognized its high duty to humanity in this respect. I do not refer to our hundreds of privately endowed hospitals, clinics and similar institutions. Their services to the unfortunate are too well known, too widely recognized, to require repetition. But I can not forego this opportunity to pay my respects to you medical men, medical men and women, too to *you*, individually. I know from countless reports how hard the sledding has been, these past years, for medical men everywhere, the city specialist and the country general practitioner. I know you people, some of you, have had a hard time making ends meet. And yet I venture to say not one of you, not one of you here today, not one of you throughout the country, not one of you but has, upon occasion after occasion, given unselfishly and unsparingly of your time, your skill, your knowledge, time after time, without thought of compensation. To little individual families in your home communities or neighborhoods, to individuals — just plain people — *good* people! The good people of this State and Nation owe you, our doctors, an undying debt of gratitude, not for some great institutional, machine-like functioning (although for these, our great clinics and hospitals, we are grateful, too), but for your *individual*, countless many kindnesses.

You have been truly America's Good Samaritans.

### UTAH STATE MEDICAL ASSOCIATION PREPAYMENT PLAN.

The House of Delegates of the Utah State Medical Association has endorsed a plan of combined hospital insurance and cash indemnity for a limited amount of medical care. The hospital plan follows the general lines of existing plans as reported in the J.A.M.A., except that anaesthesia and laboratory and x-ray services are provided for on a cash indemnity basis instead of being included in hospital care. The annual premium for the hospital plan is \$10 for an individual, \$18 when one dependent is included and \$24 for an entire family regardless of size.

Only those who are covered by the hospital insurance plan are included in the cash indemnity plan for general medical care. The additional premiums are exactly the same as for hospital care, making \$21.60 annually for an individual, \$36.00 for an additional dependent and \$48.00 for a family for both hospital and medical care. The amounts to be reimbursed to the insured for various medical services are set forth in a schedule and surgical services are limited to one major and one minor operation per member in a single year.

Enrollment is confined to employed persons and to groups which may be either employees of a common employer or "members of church and fraternal groups and their dependents agreeing to collect the necessary membership fees by assessment for subscription, remitting through a designated agent."

*N. Y. State Jour. Med. April 1939*

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(SEE PAGE 2.)



## Life Insurance As An Investment

R. B. COOLIDGE,\*  
Hartford, Connecticut

Twenty-nine years ago in one of the large eastern cities a young physician faced his first investment problem. He had reached the point where his income was slightly in excess of his expenses, and it was necessary that some plan be adopted by which this excess could be saved and accumulated.

The Doctor spent a good deal of time in solving this first investment problem because he was interested not in just a single investment, but in a plan which could be followed for years to come.

One of the things which he was particularly interested in was an investment plan which would not require very much time and effort and study on his part. To quote his own words, "I made up my mind that I wasn't smart enough to get to the top in the profession of medicine and at the same time become an expert financier and investor."

Finally the Doctor reached an unusual decision for that day. He decided that at least for the next few years he would place all of his surplus earnings into life insurance. He has continued the practice ever since.

Today he is still practicing — though not from necessity. He has one of the finest practices in his city and will probably never give it up until health or advancing years make it impossible for him to carry on. But the interesting point of our story is that the Doctor could retire at any moment and, without changing his scale of living one iota, he would never have a minute of financial worry so long as he lived. He has seen other men — contemporaries of his — who after a lifetime of splendid service to the profession have little more today than when they started practicing. He has seen others — men of great promise — who never seem to quite fulfill that promise. There may have been many reasons for the failure of their achievements to equal their apparent abilities, but in the opinion of the Doctor one important reason is the worry and the care and the time and effort that these

men have had to devote to their investment problems.

The excellent results which this one Doctor achieved with his plan are no indication that the same plan would be sound procedure for everyone. Most people, including the writer, would prefer to place some money in various types of investment. Nevertheless, the reasoning behind the Doctor's plan contains so much truth that it might be well to give some thought to life insurance as an investment for a substantial portion of the physician's dollar.

What does life insurance have to offer as an investment in addition to its obvious advantages for the protection of one's family? There are several advantages which could be enumerated, but the most important ones are: safety, freedom from care, freedom from worry, reasonable return, definiteness, emergency advantages and the annuity principle.

The most important characteristic of any investment, particularly for the professional man, is safety. The record of solvency of the life insurance companies through the depression is ample evidence of the safety of an investment in life insurance.

Freedom from care and worry is a more important factor than most of us realize. In a life insurance investment one merely mails a check when the premium falls due and the insurance company does the rest. It is the one investment which one can lock up and forget.

The return from the investment portion of a life insurance premium is very fair when the degree of safety is taken into consideration. It compares with the return of other investments of the highest grade.

The definiteness of the life insurance investment is a distinct advantage. Thus if one wishes to provide an income of \$100 per month or \$500 per month to begin at some definite date in the future, a specific annual premium may be quoted which will produce that income. The insured

\*Superintendent of Agencies, Aetna Life Insurance Company.



merely sends a check for that amount each year and at the designated time the income is forthcoming.

The liquidity and value as collateral of an investment in life insurance are extremely valuable in emergencies. The cash surrender value of the policy is known in advance and printed in the contract. The policy may be liquidated for this amount and it is not subject to any fluctuation due to current market conditions. Similarly, should one need an emergency loan the collateral value of the contract is known in advance and any condition of "tight money" will have no effect upon it.

The annuity principle is one possessed only by the life insurance investment. In recent years there has been a very rapidly growing recognition of its value. In the lives of most of us there comes a time when we either want to or must retire. When that time comes there are very few who have accumulated a sufficient sum to enable them to live upon the interest income which those accumulations will produce. Particularly in these days of low interest rates is this problem an acute one.

But if the interest income is not sufficient then it must be augmented by withdrawals. But how much? This is more of a dilemma than many of us realize. If our withdrawals are too much, the principal will be exhausted too quickly and a time will arrive when there will be no principal or income left. If, on the other hand, we want to make sure that the principal will last as long as we live, the withdrawals may have to be so small that we will have to do without many of the things which we are accustomed to and which we need for our comfort and happiness. The solution of the problem is the scientific distribution of both principal and interest under the annuity principle. Through this principle the insurance company calculates the income which can be produced over the expected lifetime of the investor, utilizing both principal and interest, and then guarantees that income for life. The insurance company is able to do this because of the large number of lives involved, and because of the application of the law of averages.

Since life insurance possesses so many advantages as an investment and since those advantages are of particular value to professional men, it would seem highly important that the physician acquaint himself with life insurance as an

investment and give consideration to a plan which would include a generous amount of it in his investment program.



### NEW ZEALAND PHYSICIANS OPPOSE SOCIALIZED MEDICINE

Basing their action on the grounds that the New Zealand Socialist Government's social security plan is wrong in principle and that it would result in concentrating treatment in hospitals where only lower grade services from salaried physicians would be available, the physicians of that country have come out in open opposition to the plan.

The government had planned to turn over annually to the medical association a fixed sum of money to be divided among themselves as they preferred. This plan was contrary to the medical association's principles and its national health committee made no arrangements with the government to put the plan in operation.



### CONNECTICUT OCCUPATIONAL THERAPY SOCIETY

It was a pleasure to see the Connecticut Occupational Therapy Society meeting in conjunction with our own State Society at New Haven in May. Those who visited their exhibit can testify to the need which this group is filling in the practice of medicine today. Occupational Therapy is one of the newer treatments for general hospital patients and takes its place with the Medical and Nursing service in the hospital. The Hartford Hospital has a very active department and, although not a training center for Occupational Therapy students, has from time to time been asked to take students from the Philadelphia and Boston Schools of Occupational Therapy.



### OPEN FRONT TOILET SEATS

Apparently plumbers, plumbing supply houses and other stores selling toilet seats are not complying with the state sanitary code regulation 127 which provides that "all new toilet seats or replacements shall be of the open front type on and after January 1, 1939." The State Commissioner of Health urges compliance with the law as a sanitary measure.

# A High School Program for Case Finding and Education in Tuberculosis Control

CLEMENT F. BATELLI, M.D., Dr. P.H.\*,  
New Haven, Conn.

Experts in the field of tuberculosis control have emphasized the importance of an approach to the problem of tuberculosis prevention through public education and mass tuberculin testing and x-raying of susceptible groups.

Education has been carried on by national, state and local tuberculosis associations so that today information regarding tuberculosis has been fairly well disseminated throughout the various communities. But the fact that information concerning tuberculosis has been carried to every nook and corner of our country is no guarantee that the public has acquired the necessary knowledge to make it tuberculosis conscious. On the contrary, if one were to question his neighbor regarding this point, one would soon realize that the average citizen has given relatively little, if any, consideration to the problem.

And why have we failed in this important work? We have failed because we have made little effort to interest the present generation in tuberculosis prevention, and to teach our school children the essentials of one of the most important health problems of the day. It may be too late to educate parents about this important matter, but if we are going to succeed in eradicating tuberculosis from our midst, we must instruct our young people in a more effective manner than heretofore. Dr. J. A. Myers points out that, "This is the time when children are receiving their formal education, and in connection with this education, they can be taught how to control one of the greatest scourges of the human family," (1).

The tuberculin testing and x-raying of large numbers in the population is not a new procedure and has been in use rather extensively in various parts of the country. Thousands of school children and college students have had the test administered during the past ten years. Several

communities have extended this work, making it available to all citizens requesting it. An example of this is the City of Detroit, where thousands of individuals have been tested and x-rayed either by their own family physician or by the clinic. Tuberculin testing and x-raying of positive reactors is now a routine procedure in many of our leading universities. Dr. W. P. Shepard of San Francisco states that, "Tuberculin testing and x-raying of positive reactors is of proven value. The time has come to include this device in the official public health procedure of school boards and health departments," (2).

Realizing the need of extending our present efforts both in the field of education and in case-finding, the Department of Health of the City of New Haven, with the cooperation of the Board of Education, drew up the following plan for carrying on a tuberculin testing and x-raying program in the senior high schools in the city.

- (1) That the director of the Bureau of Tuberculosis be permitted to carry on a tuberculin testing and x-raying program in the senior high schools, the students consenting to the test on a purely voluntary basis.
- (2) That this work be carried on during regular school hours.
- (3) That a certain amount of education precede the tuberculin testing program, such as, regular instruction by teachers, talks to teachers and students, use of motion pictures, and distribution of appropriate literature.
- (4) That the Powers' Rapid Paper x-ray machine be used in taking x-rays of all positive reactors found in this survey, the cost to be borne by the students, (seventy-five cents.)
- (5) That this program be expanded from year to year until it becomes a routine pro-

\*Director, Bureau of Tuberculosis, New Haven Department of Health.



cedure for the following groups of children: Ninth grade and senior year in high school.

- (6) That the above program be explained to the Medical Profession and endorsed by them before putting it into operation.

There are several advantages in the plan as outlined above. Teaching of health rightfully belongs in the school curriculum and should be taught by every teacher. Moreover, the subject, tuberculosis, readily lends itself to teaching, and may not only be taught in the science courses, but also in other classes, such as English, Mathematics, Drama, and Physical Education. In this way the problem of Tuberculosis Control will be strongly inculcated in the minds of the students, to be remembered throughout life and thus aid greatly in the control of this disease in their generation.

Another advantage is that this program is not a hit or miss affair but one that has been thought out and planned according to the best methods in practice today. This plan gives every parent the opportunity of knowing whether or not his child has been exposed to tuberculosis, and if he has been, to have an x-ray taken of his chest. A child with a positive tuberculin test may be checked up year after year by x-rays at a nominal cost. In this way early cases of tuberculosis may be discovered.

The cost of this program to the parents, including the tuberculin test and x-ray is only seventy-five cents. This sum is so small that practically every parent can afford to have this done. A special fund is available to take care of a portion of those who cannot afford to pay for this service.

The foregoing plan was presented to the Committee on Professional and Public Relations of the New Haven Medical Association and has received its approval and support.

#### **School Education**

Several months before the actual testing began in the high schools, a teaching unit on tuberculosis was developed by the head of the Biology Department with the aid of her staff and the Department of Health. This unit was used in teaching Biology students for a period of four weeks. Students not taking Biology had the plan of tuberculosis prevention explained to them by selected pupils in Biology. The pupils were requested to write essays and stories on

tuberculosis for extra credit. Some of these stories appeared from time to time in the school papers. A permanent exhibit on tuberculosis was set up in the schools and appropriate literature distributed to the students. Several talks on tuberculosis prevention were given and motion pictures were shown to the entire student body and to certain selected groups, including the Health Council, Biology staff and Science Club. The local newspapers kept the public informed regarding the progress and results of the program.

#### **Results of First Year's Plan**

The total enrollment of the New Haven High School, Commercial High School and Boardman Trade School is 6,850. Of this number 80.2 per cent consented to the test. Five thousand, five hundred students were tested, of whom 2,005, or 36.4 per cent, were found to have a positive reaction to the tuberculin test. There was no marked difference in the percentage of positive reactors found among the boys and girls tested. Two thousand, seven hundred and twenty-one boys were tested with 37.7 per cent positive reactors, and 2,779 girls with 35.2 per cent positive reactors.

In the New Haven High School program, P.P.D. was used, both in the first and second test strengths, while in the other two schools, namely, Commercial High and Boardman Trade Schools, old tuberculin, 1-50 mgm was used for the first test and 1 mgm for the second test. It will be noted from the attached tables that in both instances the percentage of positive reactors to the first test was 26.6 per cent. On the other hand, with P.P.D., second test strength, there were found 18.8 per cent more positive reactors as compared to 10.3 per cent with 1 mgm old tuberculin. In other words, there were almost twice as many positive reactors found with the second test strength of P.P.D., as were found with 1 mgm of old tuberculin. This result would seem to indicate that the second test strength of P.P.D. is more potent than 1 mgm of old tuberculin.

The Powers' Rapid Paper x-rays were used in x-raying 1,509 positive reactors. Of this number 151, or 10.0 per cent, were found to have some pathological changes in the lungs. There were found 136 cases of childhood type tuberculosis and 11 of adult or re-infection type. Of the



11 minimal cases diagnosed by x-ray, 7 were healed, 3 with a question of activity and 1 was found to have bilateral pulmonary tuberculosis with cavitation and positive sputum. This latter case was immediately removed from school and sent to a private sanatorium for treatment. Other lung conditions found were: — a case of fibrosis of the lung, etiology undetermined; an old case of diaphragmatic pleurisy; an unresolved pneumonia; a hemangioma of the fifth rib of the right chest. This latter condition is quite rare, in fact only thirteen such cases have been noted in the literature.

It appears from the above results that a definite plan for the tuberculin testing and x-raying of positive reactors can and should be carried on in our high schools. Education in tuberculosis prevention should be made available to every high school student. That this is of proven value is brought out by the fact that in New Haven High School every student taking Biology requested the tuberculin test, while only 68 per cent of the remaining students volunteered to have the test performed. This would seem to indicate that the students to whom the problem of tuberculosis control had been explained realized the need of the tuberculin test and x-ray and accordingly took advantage of the services offered. The fact that almost 500 positive reactors failed to have an x-ray lends support to the contention of many people that health services of this nature, in order to be one hundred per cent effective, must be furnished entirely free. There is no doubt that if this had been the case, all of the 2,005 positive reactors would have been x-rayed.

The successful achievement of our objective in this undertaking depends upon the close cooperation of the teachers, the parents and the medical profession in carefully carrying out the following plan:

- (1) All students found with any evidence of tuberculosis must be carefully followed, either by their own family physician or by the clinic.
- (2) All positive reactors with negative x-rays must be x-rayed periodically in order to detect, as early as possible, any lung pathology.
- (3) All negative reactors should be retested from time to time, and if found positive, x-rayed.

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**RESULTS OF THE TUBERCULIN TESTING  
AND X-RAY PROGRAM IN NEW HAVEN  
HIGH SCHOOL, COMMERCIAL HIGH  
SCHOOL AND BOARDMAN TRADE  
SCHOOL 1938**

**Tuberculin Test**

Total number enrolled.....	6,850
Total number tested.....	5,500
Per cent tested.....	80.2
Total number found positive.....	2,005
Per cent found positive.....	36.4
<i>Males</i>	
Total number tested.....	2,721
Total number found positive.....	1,026
Per cent found positive.....	37.7
<i>Females</i>	
Total number tested.....	2,779
Total number found positive.....	979
Per cent found positive.....	35.2
(of the 5,500 tested, 321 refused second test)	

**X-Rays**

Total number X-rayed.....	1,509
Total number failing to have X-rays.....	496
Total number found positive.....	151
Per cent found positive.....	10.0
Primary infection type tuberculosis (childhood parenchymal, cervical glands).....	136
Per cent of total X-rayed and found to have a primary infection type tuberculosis.....	9.0
Adult (reinfection) type tuberculosis.....	11
Percentage of total X-rayed and found to have adult type tuberculosis.....	0.72
<i>Minimal Cases</i> .....	11
Healed.....	7
Question of activity.....	3
(1 re-exrayed and found neg.)	
Active with cavitation and positive sputum....	1

*Other Lung Conditions*

Fibrosis of left upper lung.....	1
Old pleurisy.....	1
Unresolved pneumonia.....	1
Hemangioma of 5th rib on right side (rare).....	1

**TUBERCULIN TESTING PROGRAM NEW  
HAVEN HIGH SCHOOL, 1938  
P.P.D. FIRST AND SECOND STRENGTHS  
USED**

<i>First Test Strength</i>	
Total number tested.....	3,200
Positive.....	852
Negative.....	2,348
Percentage pos.....	26.6

(Continued on Page 385)

# State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

## Public Health Approach to the Prevention of Mental Illness

JAMES M. CUNNINGHAM, M.D.\*  
Hartford, Conn.

When the results of scientific inquiry are applied to practical problems, there develops an organization for this purpose, and a method of application which is suited to the problem. Frequently, over a period of time, the organization becomes identified with the methodology used. As the organization grows and takes on related or new activities, there is a tendency to impose on the new problem, the procedures which have been found to be successful. This causes no difficulty if the methodology happens to be suited to the problem and is capable of dealing with the basic causes of the difficulty.

The above remarks are pertinent to the development of public health and mental hygiene. Each has had an historical development which originated from efforts to deal with quite different problems. Broadly conceived, public health is an inclusive term which is concerned with the health of all the people, no matter whether it is physical or mental. While the division into physical and mental is no longer considered justified, and in fact is believed to be an artificial dichotomy of the function of the total organism, nevertheless, historically speaking such a division was made.

For a long time medicine was concerned largely with researches into the causes of organic diseases and has been brilliantly successful in those conditions for which an infectious agent could be found. Public Health organizations were originally developed for the purpose of controlling or preventing the spread of infectious or communicable diseases, and methods suitable to this problem were developed which have been highly successful for this purpose. The diseases

which were of greatest importance were those which tended to be epidemic. Out of methods which have been developed for the control of epidemics arose the science of epidemiology. It is only since the major epidemic diseases have been controlled that public health organizations have turned with equal interest to the endemic diseases.

Organizations and methods for the prevention of mental disease have had a different historical evolution. Originally, concern over mental health was merely a matter of segregation of the "insane" in asylums, primarily for the protection of society. This was a forward step to many of the abuses which were the result of superstition. The next advance was the change from asylums to hospitals, which involved a change in the concepts held about insanity. Progress was made in the direction of the treatment of insane persons as patients.

However, psychiatry in this period was influenced by the rapid advances being made in medicine as the result of bacteriological and chemical investigations. Research along organic lines seemed to hold a promise for the solution of the problems connected with mental disease. The finding of the spirocheta pallidum as the cause of general paralysis added further impetus to research along these lines.

Gradually there developed a recognition that, except for specific organic involvement of the nervous system, mental disorders were merely forms of adaptation which individuals developed in attempting to deal with the problems of life. Furthermore, there came a realization of the fact that the separation of human activity into phy-

\*Director, Bureau of Mental Hygiene.



sical and mental was merely a matter of words and concepts in the minds of those discussing the problem and did not represent an actual dichotomy in human behavior. Work done in connection with the psychoneuroses led to an appreciation of the fact that modes of human adaptation could be traced back over a long period of years to patterns of response initiated to deal with problems presented to children. There was recognition of the fact that constitutional, as well as acquired, physical handicaps entered materially into the ability of the individual to adapt himself to the problems of living. Of equal importance in conditioning the type of adaptation response were the experience and events to which the individual had to adapt himself.

In view of the fact that patterns of behavior which bring satisfaction to the individual tend to become fixed and to be used to the exclusion of others, it became apparent that prevention in the field of "mental diseases" had to deal with those things which conditioned the early behavior responses of the individual. Organizations and methods were developed to deal with those children showing early signs of developing methods of response which would, if continued, be inadequate for the responsibilities of adult living. Methods in this field are still in the process of development or evolution.

In recent years there have been two tendencies which seem to be making for a closer association between public health in the conventional sense and mental hygiene also in the conventional sense. One of these tendencies is the gradual recognition that all illness has an emotional component and that many of the conditions ordinarily considered organic may be reversed in their development by attention to emotional factors involved. This has led to a whole new field to which is currently given the title of psychosomatic medicine. This has also meant the broadening of the interests of psychiatrists to many diseases conventionally considered outside of their province and belonging to the internist, the pediatrician, the surgeon, the gynecologist and so on.

Likewise, there has been a tendency from the other direction, because of the extension of the concept of prevention, for those in public health to become interested in methods which may be used for the prevention of mental illness. This

interest seems to be a part of the widening of interest to include endemic as well as epidemic diseases and is in keeping with a broad conception of the responsibilities of public health. While this concern with the prevention of mental illness has been a part of the program of public health in Connecticut for nineteen years, it is only relatively recently that there has been any marked impetus in this direction on the part of public health on a national scale. The tendency, however, was clearly in evidence at the recent symposium on mental health of the Section on Medical Science of the American Association for the Advancement of Science.

With this historical background in mind, it may be easier to understand and to solve some of the divergent points of view about prevention of mental illness. A recent writer on the subject<sup>1</sup> approaching the problem from the conventional public health point of view, has made some suggestions with regard to the development of a program of prevention. The statement is made that, "In expanding the science of public health to include endemic disorders of a physical nature, methods of prevention that depend on the early recognition and treatment of established disorder have not ordinarily been replaced by those of epidemiology". This implies that they should be so replaced. This is an example of the tendency to apply a methodology which has been successful in one field to another set of conditions. There is no logical necessity for this and may be done only if the methods are applicable to the new set of conditions. The methods of epidemiology have developed entirely because of the practical necessity of dealing with epidemics, and have been conditioned by the causes which produce epidemics. If the causes of endemic disorders are different, it is not likely that the methods of epidemiology will be successful.

The significance of this lies in the differences of opinion with regard to what is prevention and what is treatment. If the concept is developed that prevention consists only of those methods which effect masses of the population as opposed to individuals, then prevention will be limited to those conditions which can be so effected. Obviously, it is more economical to be able to effect changes which will have a mass effect, but unfortunately this is not always possible. Attention might be called to the fact that even in epidemiology there have been developed indi-



vidual procedures, where mass methods were not available. One has only to mention various types of vaccination and immunization procedures to bring out this point.

It is probable that prevention in the field of mental diseases will be concerned largely with the early recognition and treatment of personality and behavior disorders in children. There are certain exceptions to this, such as illnesses connected with syphilis and other infections, toxins such as alcohol and drugs, and arteriosclerosis. Then, too, there are many economic, social and cultural conditions which can be changed only by methods appropriate to them. Changes of this kind we know are usually very gradual, and are usually not affected by strictly medical methods. Medical research may be in a position to indicate needed changes of a social or cultural character, by a determination of the effects of such conditions on the mental health of individuals.

Because of the nature of the problem, separation of causative agents from the individual will in most instances be impossible. The concern is with the form which the total response of the organism takes. Practical steps to deal with it may involve the elimination of physical defects, the changing of environmental conditions, or a "re-conditioning" or "re-education" of the individual. At this early age few children can be said to have a mental disease, yet they do show patterns of behavior, which if allowed to develop, will be eventually labelled with a nosological tag of some sort.

It would seem important then to recognize that methods do not dictate the solution of the problem of endemic disorders, but rather that the nature of the various problems will dictate many different methods suitable for their solution. This is particularly true in the field of mental diseases which includes such a wide variety of conditions that it is unscientific to talk about a *method* for the prevention of mental disease.

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#### FLYING HOSPITALS ARE UNCLE SAM'S SPEEDIEST AND NEWEST MEDICAL AIDS

Flying hospitals — speediest and newest of Uncle Sam's medical aids — are maintained at eight air bases along both coastlines and the Gulf of Mexico, according to an article by S. R. Winters, of Washington, D. C., in the February issue of *Hygeia, The Health Magazine*.

Twenty-one seaplanes are poised ready to answer medical calls from ships at sea. Aid to injured sailors and passengers and removal of persons from disabled vessels are the usual services they render. "NCU," meaning "any Coast Guard unit," is the radio call that summons one of these planes. This request for medical assistance is given right-of-way.

The idea was first put into practice a few years ago when five seaplanes, known as flying lifeboats, began their task of rescuing human lives out at sea. The planes carry a crew of four, and twenty passengers may be accommodated in an emergency. They are constructed to make landings on rough seas if necessary. Each one is equipped with a collapsible lifeboat and has stretchers for removing the injured from ships. The planes are met at their landing field by ambulances to rush the patients to the nearest hospital.

In addition to these services the planes endeavor to warn people of impending danger and assist extensively during floods and other disasters by transporting serums and biologic supplies and scouting the afflicted areas for purposes of operation planning.

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(SEE PAGE 2.)

# The JOURNAL of The Connecticut State Medical Society

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Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

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**NEWS.**— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

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## • Editorials •

### MORE ABOUT THE WAGNER BILL

So much has been said and so much written, both in the lay and medical press, concerning Senate Bill 1620, "a bill to provide for the general welfare by enabling the several States to make more adequate provision for public health, prevention and control of disease, maternal and child health services, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance, and training of personnel; to amend the Social Security Act; and for other purposes," — so much, in fact, that it seemed superfluous to carry on the discussion further in these columns. This was our opinion before the recent annual meeting of the House of Delegates but at that time the discussion on this bill disclosed a glaring ignorance of its contents. The other reason for our silence on this subject is the fact that we expressed in the March issue of the Journal our opinion that no national health insurance bill would pass Congress this year. To this opinion we still adhere, nevertheless, another year is coming and advocates of the so-called Wagner bill will not rest until their battle for legislation of this kind is won or very definitely defeated.

Mr. Wagner introduced his bill on February 27, 1939, when it was twice read and referred to the Committee on Education and Labor. The bill is a long one covering forty eight printed pages of usual size Congressional form. It has been characterized by a variety of terms, chief among them indefinite and nebulous, but there is really nothing very nebulous about the eight million dollars to be appropriated for its enactment the first year, the twenty millions the second year, the thirty five millions the third year, and so on. All of this means increased taxation, State and Federal, money is not to be made by the government in any other way.

The Wagner bill covers the following subjects: (1) Maternal and Child Health services; (2) services for crippled children; (3) administration of grants to States for maternal and child welfare; (4) public health work; (5) grants to States for hospitals and health centers; (6) grants to States



for medical care; (7) grants to States for temporary disability compensation; (8) rules for the determination of the financial status of States.

The maternal and child health services, the provisions for crippled children and maternal and child welfare contemplated by this bill propose nothing new but merely an extension of those services already provided for under the present Social Security Act. In the case of the provisions for public health work we find contemplated an enlargement of the present program, subject to an increase in Federal control and supervision. Each of these types of services is to be supported by a variety of complicated methods for determining the proportion of funds to be allotted to the several States.

As pointed out by the editor of the *Westchester Medical Bulletin*, the allotment of Federal funds to the States for hospitals and health centers are to be made by the Surgeon General with the approval of the Secretary of the Treasury, having taken into consideration the hospital needs of the State and the financial resources of the State which are to be measured by the per capita income accruing to the inhabitants thereof as determined jointly by the Secretary of the Treasury, Secretary of Labor, and the Chairman of the Social Security Board annually.

Likewise, the allotments for medical care would be determined in accordance with rules and regulations prescribed by the Social Security Board, taking into consideration the population of the State, the number of individuals in need of the services, the special health problems of the State and the financial resources determined as above described.

The provisions for extension of hospitals and health centers enable the Surgeon General to help the State to construct and improve governmental hospitals and to assist the State temporarily in meeting the operating costs of the added facilities. No provision is evidently made whereby any non-governmental charitable hospitals can be aided in making improvements or extensions, nor is the construction of new hospitals of this class evidently to be promoted. The allotments to the several States for the provision of medical care are to be made under the authority of the Social Security Board. They are intended to extend and improve medical care, including all services and supplies necessary for prevention, diagnosis and treatment of illness

and disability, and to develop more effective measures for providing such care, including the training of personnel. State plans, looking toward these purposes and reimbursement for same, must be approved by the Social Security Board. No limits or qualifications are found in the bill as to the permissible extensions and improvements of medical care that a State may make, or as to whether such care shall be provided through a State medical service or by a system of State health insurance, or by payment for services on a fee basis. Presumably these matters are left to the pleasure of the Social Security Board.

The bill insists upon the provision of methods of establishing and maintaining standards of medical and institutional care, to be prescribed by the State agency after consultation with such professional advisory committees as the State agency may establish. Each State must also provide for an advisory council or councils, composed of members of the professions and agencies public and private that furnish services under the State plan, and other persons interested or informed about these services.

In the Annual Discourse presented before the recent annual meeting of the Massachusetts Medical Society, Dr. Elliot P. Joslin offered several reasons for opposing the Wagner Act. Dr. Joslin is not a reactionary individual seeking to condemn the Wagner bill but a student of the nation's medical needs as they exist today. Like many another physician, Dr. Joslin recognizes that the bill contains much that is commendable but as a whole, in the form written, it will not provide a solution to the problems of medical practice.

Dr. Joslin believes that the Wagner Act should be opposed for the following reasons:

1. We as American people do not wish to be plunged further into debt.
2. The medical profession does not wish to become subservient to the government in the carrying out of its health work, both preventive and therapeutic.
3. No radical measures should be tried out in this country where the health record is so excellent without first considering methods previously in operation.
4. To extend such services to forty million people in one stroke would be dangerous, since



there are not sufficient public health doctors prepared to carry them out.

5. Politics already plays a part in health matters. Forty thousand doctors politically employed would be disastrous. The Public Health Service should be expanded gradually.

6. The W.P.A. and the Social Security Act have not been satisfactory and should first be improved before embarking on new ventures.

7. The allocation of medical funds as provided in the bill is dangerous.

8. The hospital building program proposed is disturbing. We should look before we leap.

Copies of the Wagner Act are available to our members. Secure one, read it and formulate your own opinions.



### SCHOOL HEALTH LAWS

Quite recently a special committee of the Westchester County Medical Society called attention to the need for revising the laws of New York State which relates to school health activities. To those who are familiar with Connecticut school health laws, it is evident that the need for revision is almost as great in this State as in our neighbor State.

The school health program has undergone considerable change in the past few decades. Originally a system of medical inspections for detecting signs of contagious disease, it later became a program of health examinations aimed at the discovery of physical defects. While still concerned with contagious diseases and physical defects, the present day school health program is more than a series of inspections or examinations. Present day concepts were outlined in a statement of school health policies drawn up by a state-wide school health committee and abstracted in the February issue of the Journal. This statement emphasizes the provision of a sanitary and mentally healthful environment for pupils; the health supervision of pupils during school hours; teaching pupils about the functioning of the human body and the prevention of disease; and guidance of pupils in need of medical care to their private physician or, if necessary, to community facilities providing medical care for the needy. The present day school program dispenses no medication, gives no specific diagnosis and preserves and fosters the relationships of pupils with private physicians. With these changes, the physician in the school is now con-

sidered a medical advisor rather than a "medical inspector" or "school physician."

These changes have not been reflected in Connecticut school health laws. These still require that "each child attending the public schools . . . be separately and carefully tested and examined at least once each school year . . ." The law requires Boards of Educations in towns of more than 10,000 inhabitants to appoint a school physician, but no provision is made for specifying what this physician should and should not do.

It is hoped that the school health committee will be able to have Connecticut school health laws brought into agreement with the best medical thought in this field.

C. C. W.



### THE NEGRO PHYSICIAN IN THE UNITED STATES

The Medical Society of the State of New York, through one of its delegates, presented to the House of Delegates at its recent session in St. Louis a resolution urging that membership in the national organization be not denied solely on the basis of race, color or creed. Very apparently this resolution referred particularly to the Negro physician. Certain arguments for its acceptance were embodied in the resolution. A rapidly changing social order is recognized and to meet and solve the problems of medical care of the public a united front of all elements engaged in the practice of medicine is necessary. The total of more than 5,000 negro physicians in the United States are directly responsible for the care of approximately thirteen million citizens "whose collective health problems form one of the most challenging areas in the entire battle-line against sickness and disease." These same Negro physicians should receive the same opportunities for medical education and experience that their white brothers have. Negro physicians are excluded from membership in county and state societies south of the Mason and Dixon line and hence are unable to affiliate with the American Medical Association. Such exclusion along racial lines is contrary to their rights and lowers the quality of medical care which they must deliver to an already underprivileged group whose health problems are greater than those of any other group in this country.

On the surface the case for the Negro physician seems fairly simple and clear cut, but there is

much more to it when one delves deeper. It is not surprising that a group of northern physicians should champion the Negro. New York City's own Harlem contains a large black population which is indeed a major health problem. But it is difficult for any one born and raised north of the Mason and Dixon line to appreciate the particular place the Negro fills in the family life of the South. Indispensable to the family of any size, even though the days of slavery are rapidly becoming but a dim memory, he is accorded rights and privileges that a few servants in the North could ever claim. Unfortunately the health problem lies with a large number of this race which no longer enjoys the protection of the white man's roof and it is among these colonies that the Negro physician carries on his practice.

At the time the American Medical Association met in St. Louis when the resolution concerning Negro physicians was presented and defeated, the editor of the Richmond (Va.) Times-Despatch, strangely enough, championed the case for the Negro. He warns us and perhaps rightly that, although defeated in the House of Delegates this year, the question has not been permanently dismissed. He repeats the statement made by the New York delegates that Negro physicians are systematically excluded from county and city medical societies in the South and thence from membership in the American Medical Association and that through this exclusion from white medical societies they are largely denied the benefits of reports on research presented at these meetings. This editor is of the opinion that Negro medical societies have lagged behind the general organizations in their development and, as a result, colored physicians "have been seriously discouraged in their attempt to continue their education." Most of the physicians of the black race are general practitioners, only a small number of them are in any of the largest cities of the South and, according to the same editor, "unless the Southern white physicians open the doors of their local societies to these doctors they cannot get in touch with the vital current of medical thought in America."

To all of this the editor of the Virginia Medical Monthly replies in a very understanding editorial in the June issue. Dr. Blanton informs us that the Southern doctor regards his Negro brother practitioner with a sincere

desire to help and a depth of understanding based on years of experience. He calls our attention to the National Medical Association composed exclusively of Negro doctors and to the Old Dominion Medical Society, in Virginia, similarly constituted. He reminds us that the vital currents of medical thought are chiefly to be found in medical journals, available alike to black and white. He reminds us that Negro doctors have been welcomed as visitors to medical meetings and that in many medical schools they are being taught side by side with white students. But where there can be no argument is in formation of medical societies which it has been advocated should be thrown open to Negro physicians. Scientific these societies are but social also many of them of necessity must be and to invite the Negro doctor and his wife and family to participate in an annual meeting on board ship where the North Carolina Medical Society met this year or to attend the banquet and ball at the closing meeting of the Richmond Academy of Medicine just could not be. The Southerner, unlike his Northern friend, realizes that there must be social isolation of the two races, white and black, if racial purity and integrity are to survive. We quote Dr. Blanton: "There are times when what is ideally right is wrong because it is impractical. That is the answer not only to this editorial (Richmond Times-Despatch) but to much of what the lay public and press have said to and about the medical profession in the last few years. Those who believe most firmly in the American way of life believe about this question as they do many another question: that doors always open to races, to sexes, to individuals, in answer to their own honest effort — effort which may have to be sustained through the years, often in hardship, often in discouragement, often in unfairness, often in injustice. Few doors open of their own accord to anyone, male, female, black or white and few doors are opened by benevolent commentators. Life is harder than that, but one of its chief glories is self-determination."



### THE 147TH ANNUAL MEETING

To some the program of the recent annual meeting in New Haven made no appeal, to others



it was just another annual meeting of the Society, but to by far the largest number of those who attended this annual meeting brought much of value. The two days were full but no one felt crowded. Dr. Patterson and his committee are to be congratulated on the excellent papers produced by our own members. The innovation introduced by the committee of having a group of papers discussed by a well known guest was a distinct success and may well be repeated in succeeding years.

Hotel Taft housed and fed us well. The commercial exhibit was a credit to the Society. Opportunities for social intercourse were not lacking and many enjoyed renewing friendships for which they have little opportunity during the year. The record attendance of 447 members and over 200 guests testifies to increasing recognition of the value of our annual meetings.

Called to order the day before the scientific program opened and again a short time on the second day of the scientific session, the House of Delegates transacted an amazing amount of business with ease and decorum unsurpassed in previous years. Attention has been called to measures passed by the House in the preceding issue of the Journal as well as elsewhere in this issue.

Our Society may well feel proud of its progress each year in better fitting itself to represent the individual practitioner of medicine.

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### THE AMBULANCE CHASER

This old and interesting subject is dealt with in a very intelligent manner in The Johns Hopkins Alumni Magazine for March of this year by Robert France, president of the Baltimore Bar Association. In February Mr. France acceded to Governor O'Connor's urgent request that he become chief judge of the traffic court as a part of the Governor's judicial improvement program. The Bar Association in Baltimore is

trying to clean its own house by investigating all cases of ambulance chasing that are brought to its attention. In addition to this, with the cooperation of the police commissioner, it sends out a form letter warning of the activities of the ambulance chaser, such a letter going to everyone reported to the police department as injured in traffic accidents. By investigation of these replies and taking proper disciplinary action ambulance chasing in Baltimore has been kept at a minimum. The chief difficulty seems to lie in securing the cooperation of the general public.

Although Connecticut cities as far as we know contain no such "rings" as have operated in New York and Chicago, yet there are rumors of attempts on the part of unscrupulous lawyers to build up such a nefarious business even in our small state. Our experience with the Connecticut Bar Association makes us certain that whenever such instances are reported to their grievance committee proper disciplinary action will follow.

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### THE PARTICULAR NEEDS OF NEGROES

I am now on duty in Northampton County. There are several maternity and infancy centers and these centers are visited not by one, five, or seven women, but by crowds. They come from far and near; a few in cars, others in carts drawn by mules, and many on foot. They keep coming, bringing their friends. Why do they come? Because the clinics are presided over by sympathetic physicians, assisted by indefatigable and enthusiastic nurses who give the clinic a wholesome and cheerful atmosphere. It is evident by the large attendance at these clinics throughout the county that these mothers are wholeheartedly accepting the facilities that have been provided for the safeguarding of their health.

*Child, Apr. 1939*

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(SEE PAGE 2.)

# From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street                      New Haven

The attendance at the 147th annual meeting of the Society in New Haven in May was the largest ever recorded. 447 members of the Society registered and there were more than 200 guests. The attendance by counties was as follows:

County	Number in Attendance	Percentage of Members
Fairfield	84	.22
Hartford	75	.14
Litchfield	13	.16
Middlesex	19	.27
New Haven	206	.39
New London	38	.32
Tolland	3	.13
Windham	9	.23

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## COMMITTEE TO STUDY OSTEOPATHIC PRACTICE ACT

The House of Delegates at its annual meeting directed the President to appoint a committee to study the Osteopathic Practice Act. Doctor Linde has appointed: Berkley M. Parmelee, Bridgeport, Chairman; Charles T. Flynn, New Haven; Frank T. Oberg, Hartford.

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## COMMITTEE TO STUDY PREPAID MEDICAL SERVICE

The House of Delegates at its annual meeting directed the President to appoint a committee to study Prepaid Medical Service. Doctor Linde, has appointed: Samuel C. Harvey, New Haven, Chairman; Thomas P. Murdock, Meriden; James R. Miller, Hartford; Oliver L. Stringfield, Stamford; Daniel P. Griffin, Bridgeport.

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## MEMBERS OF FORTY YEARS STANDING

There are seventy-eight physicians who have been members of the State Society for forty years or more. The House of Delegates at its annual meeting on May 24 directed the Council to pre-

pare an amendment to the bylaws which would exempt, at their own request, such members from the future payment of dues to the State Society. The amendment will be presented to the House of Delegates at its annual meeting in 1940.

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## STATE TO MAKE STUDY OF HEALTH CONDITIONS

House Bill 1650 creating a commission concerning the problem of physical and mental disability among the people of the State and methods for their prevention and care was passed by the Senate and House of Representatives at its recent session.

The law provides that the Governor shall appoint a commission of five residents of the State who shall study and examine into the problems of physical and mental disability among the people of the State, and the expenditures now made, or, in the opinion of the Commission necessary to be made, by the State through any of its agencies, for their prevention or for their care. The Commission is required to report its findings with recommendations on or before January 1, 1941 and shall embody in its report drafts for legislation necessary to carry out its recommendations.

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## RALPH A. McDONNELL

The Secretary notes with a feeling of deep personal sadness the death of Ralph Augustine McDonnell of New Haven. Dr. McDonnell became a member of the State Medical Society in 1893 and for nearly half a century has been a leading figure in medical affairs in the State. He served as the President of the New Haven County Medical Association in 1906 and was elected President of the State Society in 1934. At the time of his death Doctor McDonnell was a member of the committee on Cooperation with the Yale School of Medicine.



## Medical Bills in Recent General Assembly: Annual Report of Legislative Secretary.

H. B. 464, to amend the Charter of The Connecticut State Medical Society so that the President-Elect would be an ex-officio member of the the House of Delegates. This passed without any discussion and is now a part of our Charter.

S. B. 305, to create a department of professional and vocational examination and licensure. You will recall this. We put forward some direct and telling efforts in opposition to this bill early in the session. Just how much weight our efforts did carry is, of course, impossible to tell. Many other groups were opposed to the measure also. Final result: the bill was not reported out of committee.

S. B. 173, the bill that would take away from the osteopaths the privilege of appearing before the Connecticut Medical Examining Board for examination to practice medicine and surgery (Robbins Bill). The embarrassment that attended this bill has already been explained in the House of Delegates. It received an unfavorable report from the Committee on Public Health and Safety and was rejected by the House and Senate.

S. B. 931, a bill that would give the osteopaths the privilege of examining and licensing themselves to practice medicine and surgery. I will not enter into long discussion of what happened in regard to this bill other than to state that the osteopaths had an active lobby, they were constantly at work in the House, they used every means to get this bill passed. Members of the Legislative Committee and others in the State Society entered into our opposition to the measure in a wholehearted fashion and I am sure that the work that all of you did in this connection was very fruitful. It was a long, exciting and sometimes trying job. Net result: the Committee on Public Health and Safety reported unfavorably, Senator Geelan of New Haven alone voted in favor of the bill. The Committee did not report to the House in spite of efforts on the part of some to have it reported out. There is no question but what this will be a constantly recurring affair and although we

were successful in deferring it this year, we must be ready to combat it again and again.

S. B. 57, the hospital insurance plan bill. This bill which as you know, was drawn by representatives of this Society and the Hospital Association received enthusiastic support all along the line with only a little sniping made at it by an insurance agent who proposed some amendments in the hearing. These amendments were not accepted and the bill passed early in the session without any opposition. It is wise and constructive legislation.

H. B. 857, an act concerning medical service corporations. This, as you know, was somewhat of a private project of my own and went through an interesting career in the House. The bill as originally drafted by me, early appeared somewhat inadequate and another bill under the title of "Community Health Service" was introduced and my medical service bill was practically withdrawn. Then, in conference with a member of the House, the Insurance Commissioner and Doctor Allen of the Hartford Hospital, it was sort of decided to go back to my original bill, but nothing very much happened about it until the very end of the session and then through some interesting activities the Governor became interested in the project. The Committee on Insurance, before which the bill was heard, brought in an unfavorable report but in spite of this the House and Senate both passed the bill, it receiving enthusiastic support from Republicans, Democrats and Socialists alike. It was just one of those things. I frankly put it in for a trial balloon to see what might happen and what the interest in that sort of thing was. In the end it turned out to be one of the most popular measures of its kind. The law as passed provides that seven residents of this State may incorporate for the purpose of underwriting the cost of medical care on a non-profit basis and that the eight county medical associations and the State Medical Society may jointly or severally enter into such an activity. The whole affair is under the supervision of the Insurance Commissioner of the State who must

approve applicants for incorporation and must certify that they are in the public interest and any group seeking to enter upon such an enterprise must have \$5000.00 with which to begin business. Under this law The Connecticut State Medical Society and its components has, I believe, a genuine opportunity to meet one of its greater responsibilities.

H. B. 1650, creating a Commission to Study Mental and Physical Defects of the People of the State and Remedies for their Treatment and Care. This bill arose in the Committee on Public Health and Safety. It was written by Doctor William H. Coon and received a favorable report from the Committee on Public Health and Safety. The bill had the support of the Governor and passed both Houses without much of any discussion other than that which no doubt you have read, that was offered by Senator Downes of Norwich and in expressing his approval of the bill he stated that conditions in the Norwich State Hospital for the Insane demanded immediate investigation. Mr. Downes' reaction to the purpose of the bill is somewhat peculiar. It was not the intention that the commission be a fault finding one, rather, a fact finding one. The opportunities that lie ahead for this commission are extraordinary and it should arrive at conclusions of important social and economic significance. It is required to report to the General Assembly on January 1, 1941. It is likely that a member of this Society will be included in the personnel of the Commission.

H. B. 606, revising the Nursing Practice Act. It became a law with minor amendments.

H. B. 294, requiring a Wasserman on all pregnant women, was approved by the Committee on Public Health and Safety, was referred to the Committee on Appropriations because an appropriation of \$10,000.00 for the State Health Department Laboratory was written into the bill. The Appropriations Committee did not report the bill out as was to be expected in these economic minded times. A late attempt was made to get the bill from the Appropriations Committee and introduced into the House with a favorable report from the Committee on Public Health and Safety without any appropriation but this was not successful in the turmoil of the closing days of the session so nothing came of that.

S. B. 168, establishing a board of examiners for masseurs, received a favorable report of the Committee and was, I believe, finally tabled without action.

There are a group of bills that abolish the office of county health officer. These were passed. The lawyer county health officer is no more.

A group of bills amending compensation laws, increasing maximum compensation from \$21.00 to \$25.00 per week, extending the Statute of Limitations in occupational diseases, providing a lump sum indemnity of \$1500.00 for facial disfigurement in addition to other compensation payments.

S. B. 167, a bill affecting a Drug Act which brings the Connecticut law into conformity with the recently enacted Federal Statute. This is not effective in this State until July 1, 1940. It is broad and far reaching legislation.

The following troublesome bills were all defeated: a bill reviving the Eclectic Examining Board; a bill requiring all hospitals receiving State aid to permit any licensed physicians to care for a private or semi-private patient in that hospital (this was believed to be a sort of companion bill to the bill that would permit osteopaths to practice medicine and surgery, for if osteopaths were so licensed, they would become licensed physicians and would, under this bill, be admitted to practice in hospitals); a bill that would increase the payment made by the State to hospitals in the State for the care of State patients, was not reported out by the Appropriations Committee; a bill that would limit the working hours of student and employed nurses in hospitals and State institutions to eight hours a day and forty-four hours a week.

No report of this years legislative program would be complete without making note of the interest and thoughtful help that we received from Doctor William H. Coon. Doctor Coon is the only physician in the General Assembly and he was sympathetically disposed toward all of our projects. Without his aid we would have been unable to accomplish what we did. Doctor Coon was formerly a member of the State Society but resigned when he withdrew from active practice. The Society is certainly indebted to him.

Creighton Barker, M.D.



## SECTION ON Proctology

A section on Proctology was organized on May 25 in connection with the state meeting in New Haven. A constitution was submitted and adopted by the members present. Dr. Simon B. Kleiner of New Haven was elected chairman of the section and Dr. J. Grady Booe of Bridgeport was elected secretary-treasurer. The meeting was addressed by the president elect, Dr. Joseph I. Linde of New Haven and Dr. Albert R. Keith of Hartford who, in addition to being a member of the section, is president of the New England Proctologic Society.

The paper of the afternoon, "Anorectal Tuberculosis," was read by Dr. A. W. Martin Marino of Brooklyn, New York. Discussion was opened by Dr. R. Glen Urquhart of Norwich and was continued by many of the members present.

At the meeting of the American Proctologic Society held at the Hotel St. George in Brooklyn June 25, 26, and 27, Dr. J. Grady Booe of Bridgeport read a case report on "Cod Liver Oil Ointment in Treatment of Fistula." A memorial address to Dr. Raoul Bensaude was delivered by Dr. Simon B. Kleiner of New Haven. Quite a few members of the newly organized Section on Proctology were present at the meeting in Brooklyn.

The fall meeting of the New England Proctologic Society will be held in Bridgeport in October. Definite date of the meeting will be announced in a subsequent issue of this journal.

## Our Neighbors

### SURVEY IN NEW YORK CITY SHOWS FAMILY PHYSICIANS VANISHING

According to the New York Times, the Committee on Research in Medical Economics recently published a report of a survey of 365 families on the lower East Side, the West Side and in Harlem which showed 47 per cent of the families using both private and agency care, 22 per cent using private care only and 31 per cent using agency care only. The incomes of these 365 families ranged in the case of 32 per cent from less than \$1,000 to over \$3,000 in the case of 5 per cent. The report points out that the family doctor is a vanished ideal among two thirds of the families and is very imperfectly represented among the remaining third, that change from one medical resource to another is frequent, and that cost or the fear of cost is a pervasive element, commonly influencing choice, often causing delay in securing care and frequently impelling change from one medical resource to another.



### BIOGRAPHIES AND PHOTOGRAPHS

The Medical Society of Delaware is celebrating its sesquicentennial this year, three years before the Connecticut State Medical Society. In order to make their records complete biographical data and photographs are needed, especially those pertaining to physicians prior to 1875. Our own Society will be looking for such material very shortly. Even though raking up old material like that mentioned above may be a tedious and dusty enterprise it is not too early to have this in mind and thus add to the interest which may be aroused in our own Sesqui-Centennial.

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## - NEWS -

### *from County Associations*

#### Fairfield

Fairfield County physicians recently received invitations from the Danbury Medical Society for a meeting held at the Ridgeway Country Club on June fifteenth. Dr. Booth writes that the meeting was not in any way a scientific one. A golf tournament occupied the afternoon. Dinner was followed by a motion picture film in color, "the unofficial title of which is said to be 'Throwing the Bull in Old Mexico'." This film was taken by Dr. Carl Comstock, of Saratoga Springs, New York, during a recent trip to Mexico." This non-scientific medical gathering is to be highly commended and it is hoped that the members of the Danbury Medical Society and their guests will begin an annual custom.

Dr. Emil Novak, Associate Professor of Obstetrics, University of Maryland, Baltimore, spoke on the "Endocrine Influence of Certain Ovarian Tumors" at the final spring meeting of the Bridgeport Medical Association. This was Dr. Novak's second appearance before the Society and the high quality of his earlier presentation was maintained.

Congratulations to Doctors Ashcroft, Clark, Hurlburt and Zauer on the initial visit of the stork.

#### Hartford

Dr. James L. Gamble, Professor of Pediatrics of Harvard Medical School, on May 15, 1939, presented a talk on "The Pathogenesis of Dehydration, Acidosis and Alkalosis" before the Hartford Medical Society. With the increasing interest and knowledge concerning fluid balance and the importance of electrolytes in the human body in different conditions and diseases, it proved valuable to have the use, the rationale of use, the dangers and the comparative merits of various solutions which are administered intravenously explained by one who has done so much work along these lines.

President Henry N. Costello has appointed the following members to the Medical Information Bureau for one year:

M. Alvord Gore — Bristol  
David Waskowitz — New Britain  
Francis D. Ellis — Farmington  
G. A. F. Lundberg — Manchester

Dr. John A. Wentworth was recently elected President of the Bowdoin Alumni of Central Connecticut.

Congratulations are extended to President and Mrs. Henry N. Costello who celebrated their 25th wedding anniversary on June 15.

Many county members attended the meeting of the Connecticut State Medical Society held in New Haven this month and favorable comments were almost universally forthcoming. There was somewhat of a novel arrangement at the meeting this year in that the papers of members of the society and those of invited speakers were discussed by a prominent invited physician from another society. This arrangement was well received. The papers given by our own members were, however, rather brief and the subjects varied to such an extent that the one discussing could hardly do himself full justice. It is thought by a large number that at the state meeting it would be well to have formal papers entirely given by our own members who would comprise a representative group. By that we mean that a member or two from each county give a formal paper on a subject of quite general interest. Another suggestion would be for such a representative group to give a symposium on an important subject. We can think of nothing that would be more valuably covered by such a symposium than a comprehensive review of Acute Appendicitis. From it we might develop an active campaign sponsored by the State Medical Society directed towards the lowering of the mortality of this disease. Such a work might be modelled after that of the Philadelphia County Medical Society which definitely showed results. It is contended that since we have as a rule guest speakers for the Clinical Congress the papers at the state meetings should be given by our own members and a plan such as adopted this year could be followed by having papers of these members discussed by invited guest speakers.

Our sympathy is extended to the bereaved of Dr. Percy G. Drake of Hartford, Dr. William A. Dower of Windsor and Dr. George Flanagan of New Britain.

Members of the County Association elected to state offices for the ensuing year are as follows:



Arthur B. Landry, President-elect  
Edward J. Whalen, Councilor  
Stanley B. Weld, Secretary of Scientific Work and  
Editor of the Journal (re-election)

James R. Miller was re-elected Treasurer and  
also alternate delegate to the American  
Medical Association for a term of two years

Among those who by examination have successfully qualified for and obtained certificates for the American Board of Surgery are Dr. Phillip G. McLellan and Dr. Benedict B. Landry of Hartford.

On June 15, 1939, about 225 members availed themselves of the opportunity of the offer by Mr. and Mrs. Alsop of Wood Ford Farm, Avon, to inspect their modern dairy. Visits to the barns were made under the direct supervision of the owners and their foremen who all gave many interesting facts concerning the production of certified milk and the handling of the herd. At 6 o'clock a chicken supper was served in one of the tobacco barns and greatly enjoyed. Brief speeches were made by Mr. and Mrs. Alsop giving a history of their efforts in bringing their farm and their milk to the high standard which it holds. On behalf of the society President Henry N. Costello expressed thanks to Mr. and Mrs. Alsop and thanks are herewith again given.

#### Litchfield

Dr. Harry B. Hanchett of Torrington sustained minor injuries as result of an auto collision near his cottage, at Bantam Lake on Saturday afternoon, June 10. As this number goes to press, we are pleased to report that his convalescence is satisfactory.

Dr. Albert Buck, Director of the Charlotte Hungerford Hospital, who was married to Miss Ann Suderman on May 14 in Newton, Kansas, returned to Torrington on June 12 after a trip to New England and Canada. Doctor and Mrs. Buck will be at home in Goshen, Connecticut.

Dr. Emerson Hill is convalescing from an operation performed on June 9 at the Charlotte Hungerford Hospital.

Dr. Myles Standish of Hartford gave an interesting talk on various skin disorders before the Journal Club of the Charlotte Hungerford Hospital on June 1. The program of the Journal Club, which was published in the May issue of this Journal, will be completed with the meeting to be held on June 22. Dr. Ralph Ogden of

Hartford will speak on that occasion. During the months of July and August meetings will be discontinued. The program for the fall and winter session will be published in an early number of the Journal. These meetings are held in the Staff Conference Room of the Charlotte Hungerford Hospital at eleven a.m. on Thursdays. Any physicians interested are cordially invited to attend.

On June 13 Dr. Francis Sutherland spoke before the Graduate Nurses Association at a meeting held in the auditorium of the Charlotte Hungerford Hospital. Dr. Sutherland's talk on Thyroid Disease was illustrated by lantern slides.

Regular meeting of the Tumor Clinic of the Charlotte Hungerford Hospital was held on June 7 with Dr. Bradford Walker, chairman, presiding. The subject on this occasion was Carcinoma of the Colon; the pathological material was presented by Dr. Bartlett and Dr. Wilens, the roentgen diagnoses were discussed by Dr. R. T. Ogden.

#### Middlesex

A daughter, Merrilyn Hart, was born on May 14 to Dr. and Mrs. Hazen A. Calhoun, Jr.

Dr. John B. Milburn of East Hampton has announced his retirement from active practice. He has also resigned as Medical Examiner and this office will be filled by Dr. Norman H. Gardner.

The Central Medical Society held a hobby show at Bengston-Wood Hall on May 30 and on June 15 held their annual outing at Clarkhurst. The pleasing informality of both events was greatly enjoyed.

Dr. and Mrs. Norman E. Gissler of Middletown have recently returned from a fishing trip in Maine.

The Health Department in Middletown has been assigned a larger suite of offices in the Municipal Building. The Health Officer now has a waiting room and a private office. Through the efforts of Dr. Palmieri both the city and town School Boards of Education have ruled that a complete physical examination shall be required for admission of all first year pupils to school. These examinations are to be done through the family physician or through pre-school conferences held under the supervision of the Health Department.

The recent measles epidemic which swept over the greater part of the county has apparently subsided.

Dr. Richard Grant, a graduate of the Albany Medical College, has opened an office on Main Street in Cromwell. Dr. Grant recently completed his internship at the Middlesex Hospital in Middletown.

#### New Haven

Doctor Francis G. Blake, Professor of Medicine, Yale University School of Medicine, read a paper on "The Chemotherapy of Pneumonia" at the 87th Annual Meeting of the Maine Medical Association held at Poland Springs, June 25-27.

#### Tolland

The regular semi-annual meeting was held at Somers on April 18. Dr. James D. Gold discussed the needs of the State Society for a full time secretary and the consequent necessity for raising the dues to fifteen dollars. At the business meeting this measure was endorsed by the association. Dr. James R. Miller gave an interesting and instructive talk on Office Gynecology. Selection of officers for the coming year resulted as follows: President, Alfred Schiavetti; Vice-president, William Schneider; Secretary, Francis Burke; Councilor, Charles T. LaMoure; Censors, Francis Dickinson, J. McClure Givens, Frank B. Converse; State Delegate, Francis Burke.

At a recent meeting of the trustees and staff of the Rockville City Hospital a move was instituted to establish a laboratory at the hospital with a full time technician, thus filling a long felt want.

The sympathy of the society is extended to Dr. Frank Converse, whose wife died recently.

It will be greatly appreciated if anyone in possession of newsworthy items from Tolland County will send same to the news editor of the county, Dr. D. M. Beckwith, Rockville.

## Letters to the Editor

495 Orange St., New Haven, Conn.,  
June 9, 1939

Editor,  
Journal Connecticut State Medical Society,  
Hartford, Conn.

Dear Dr. Weld:

The letter Quo Vademus: An open Letter, by Anonymous, leads to the following statement regarding the recently formed American Board of Surgery.

When this Board was formed by representatives of several national and regional surgical societies, including the Surgical Section of the American Medical Association, many felt that here at last was an opportunity for every surgeon to prove his ability by examination.

But the American Board of Surgery will not examine a surgeon unless he has had one year of internship and three years devoted exclusively to surgery in an hospital approved by the Board. It will, however, certify by invitation some who have practiced surgery exclusively for fifteen or more years and also the members of certain surgical societies in which membership is by invitation. Many of the former have not had the preliminary training required of those whose surgical practice does not date back fifteen years.

The higher requirements might apply to future surgeons but should not be retroactive, and if so none should be excluded. There is no objection to certifying established surgeons but why the line should be drawn at fifteen rather than ten or five years of surgical practice is difficult to understand.

Many surgeons have improved themselves by practice, private and institutional, independent study, attendance at surgical clinics, reading of surgical literature, etc. and that this type of training is valuable is proven by the many leading surgeons of this state who have been so

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trained. Conversely, there have been some who have spent long periods of time in clinics without profiting commensurately.

The Board is apparently more interested in how much preliminary training one has had rather than how much one knows and to refuse to examine is to condemn without trial and cast reflection on many capable surgeons. It is indeed fortunate that license to practice Medicine and Surgery granted by the State is not decided in the same way.

The reason given for the formation of the Board of Surgery is to raise the standards of Surgery, not to test candidates for positions as Professors of Surgery, or for membership in the leading surgical societies.

The author of *Quo Vademus* states the important point when he mentions the sanctions put on the boards by the A.M.A. These boards have no legal standing and without A.M.A. sanction would have little authority.

The rights of the great majority of members should have been protected by the A.M.A. allowing all to take the examinations and stand or fall on their merits and the A.M.A. should have been the organization to hold the examination.

Perhaps the Board of Surgery will defeat its avowed purpose by making the standard so high that few except those invited can qualify, or maybe it is more interested in forming still another exclusive group.

Thomas J. Sullivan, M.D.

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## DEATH RATE OF PNEUMONIA WITH PREGNANCY IS HIGHER

Pneumonia complicated by pregnancy has a much higher death rate than it does in non-pregnant women, Maxwell Finland, M.D., and Thomas D. Dublin, M.D., Boston, point out in *The Journal of the American Medical Association* for March 18. It accounts for about one death in every 5,000 deliveries and is the cause of about one half of the maternal deaths not directly due to pregnancy.

Drs. Finland and Dublin studied the incidence of pneumonia in pregnancy at the Boston City Hospital. About one of every eight women of child-bearing age who had pneumonia was pregnant, 0.63 per cent of all women admitted during pregnancy or for delivery had pneumonia and in 1.2 per cent of all the cases of pneumonia the condition was complicated by pregnancy.

A study of 212 cases of pneumonia complicating pregnancy in which the type of organism causing the infection was determined, revealed that the incidence of pneumococcic types was similar to that found in all cases of pneumonia in adults. The authors state that "the types for which specific antipneumococcus serum has proved effective were the most frequent.

"Blood borne infection was more frequent in pregnancy than in all cases for the same age groups. Likewise the death rates were higher than in corresponding cases for the same age group.

"The death rates were highest for late pregnancy and for women whose pregnancy was terminated during the disease.

"The death rate for all the serum treated patients was almost one half of that for the corresponding nonserum treated patients. The lower death rates were for pneumonia complicating both early and late pregnancy, for pneumonia after delivery, and for those women whose pregnancy was unaffected.

"The frequency with which pregnancy was terminated did not seem to be influenced by serum treatment.

"The pneumonia of pregnancy are sufficiently serious to warrant the use of every available means of treatment, and the proved efficiency of specific serum treatment warrants primary consideration in those cases in which it is applicable."

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We surmise that the three most powerful potential sources of public opinion in the United States are (1) the press, (2) the radio, (3) the medical profession. The radio is already under control by government license, renewable every six months. This requirement, Mr. Elliott Roosevelt recently told the Federal Communications Commission, "tends to act as a restriction upon free speech," creating "a censorship of fear" in the radio industry. The press is dependent upon a huge financial structure which could easily be ruined by inflation or advertising restrictions. But the medical profession has no large capital structure; it enjoys licensure by states; it contacts more people in the course of a year, probably, than the press and the radio, combined; it indulges in free and independent thinking, and it is financed individually by the people of the United States.

*Westchester Medical Bulletin, April, 1939*

# 147th Annual Meeting

## Proceedings — House of Delegates

The first session of the House of Delegates of the Connecticut State Medical Society convened in the auditorium of the New Haven Medical Society at 10:30 A.M., on May 24, 1939, Dr. Hugh B. Campbell, President of the Society, presiding.

### REPORT OF THE PRESIDENT

Following the pleasant custom established many years ago, your President has visited the several County Societies at their Spring and Fall meetings, with one exception when illness prevented. The programs have been interesting and instructive, the interest in the economic problems of medicine keen, and the social association delightful. I am indebted to all the Societies for their hospitality.

The Clinical Congress, under the able and efficient committee of arrangement, continued the high standards of the past and provided a program that had most favorable commendation, not only from members of the Connecticut State Society, but from many members of the New England and middle Atlantic groups.

We are proud of the development of our Journal and foresee greater possibilities for its usefulness in medical and associated fields.

The finances of the Society are efficiently managed under a modern system with proper attention paid to the items of budget, disbursement and audit.

The program for this meeting promises to be unusually instructive and entertaining. Our thanks are due to the committee for arduous work well done.

No State Society could be more ably served by its administrative office than is ours. Its activities, numerous as they are, have not in my experience failed to care for any detail. We are fortunate.

My associations with the Council under its able and lovable Chairman have been most enjoyable. A Legislative year has added many problems for discussion and decision. I trust these and the more routine matters have been cared for to the satisfaction of all.

May I again thank you for the great honor you have conferred upon me.

Respectfully submitted,  
HUGH B. CAMPBELL



### REPORT OF CHAIRMAN OF THE COUNCIL

Mr. President and Members of the House of Delegates of The Connecticut State Medical Society:

The Council of The Connecticut State Medical Society has held monthly and interesting meetings during the past year which is an indication of progress and added enthusiasm shown by the membership of the Society. In addition, the stimulating leadership of our Executive Secre-

tary has been a help and an inspiration to develop and carry on the many interests of the Society throughout the State and nation. You will realize from the Secretary's report the vast amount of work which he has done as Legislative Secretary.

The nominations for officers and committees are on the agenda before you. All recommendations including changes in the By-Laws are printed in full in the agenda.

At the meeting of the House of Delegates in June 1939 the Committee of Twenty recommended that the State Medical Society, at its own expense, undertake a study of medical care for the State of Connecticut to be conducted by trained investigators at a cost not to exceed \$12,000. At the July meeting of the Council it was voted to disapprove of this recommendation. It was voted that a Committee of Five should be appointed by the Council to direct a study of the distribution of medical service in the State using the standard forms and outlines provided by the American Medical Association; this survey to be made through the office of the Executive Secretary by a temporary full-time organization under the direction of this committee. It was also voted that the sum of \$1400 be withdrawn from the accrued income of the Gurdon W. Russell Fund to finance the survey. The additional money to be withdrawn, if necessary, from the general funds of the Society, not to exceed \$2000 including the \$1400 from the Russell Fund. It was voted to disapprove the request of the Section on Anesthesia that they be allowed the sum of \$50.00 to defray the expenses of the speaker to address their Section.

At a special meeting of the Council held in September the delegates to the American Medical Association were invited to be present for the purpose of discussing the recommendations for a national health program made by the President's committee and submitted to the national health conference in July. These recommendations were discussed separately and approved in general but with the provision that such extensions and expansion should be done with the full cooperation and guidance of the State Medical Society.

At the September meeting of the Council they reconsidered setting up a Committee of Five to make a survey of medical care in this State. Their reasons, first, it might be desirable to have further opportunity to learn how successful the study had been in other states, second, the Council had difficulties in getting able people to accept appointment to the committee and, third, the American Medical Association was willing to admit that the time for some change in the distribution of medical service has come without further factual investigation. Following a lengthy discussion it was finally decided that the matter of making a survey of medical service in the State of Connecticut be laid upon the table. A committee was appointed with Doctor Barker as chairman, to consider ways and means



of conducting prepaid medical care insurance by the Society.

Acting upon a request from the Director of the Personnel Department of the State of Connecticut that this Society appoint a committee to make a study and recommendations concerning the employment of physicians in the institutions of the State, the Council appointed Doctor Stanhope Bayne-Jones, Chairman, Doctors Wilmar M. Allen and David R. Lyman. This committee has made a very extensive study and rendered a comprehensive report. A request from the Director of the Personnel Department of the State that this committee be continued has been granted.

At the November meeting of the Council Doctor Barker was instructed to plan for the mid-winter dinner to entertain Doctor Abell, President of the American Medical Association, Doctor Abell to be the guest speaker. The dinner meeting was held and the President of the American Medical Association held the entire assembly spellbound with his clear and concise explanation of the national health program.

The question of a full-time secretary was again brought to our attention and very fully discussed and you have the recommendation of the Council before you. A request from the Connecticut Nurses Association to appoint two of our members to their advisory board was received and Doctors B. Austin Cheney, New Haven, and Claude C. Kelly, Hartford, were appointed.

The Counties of Litchfield, Tolland, Windham and Middlesex all report well attended meetings with an increase of membership.

New London county is a live association. All questions receive full discussion and inquiry before acceptance by the membership.

New Haven County Association is flourishing and a very sincere and true medical spirit prevails.

In Hartford County six hospitals became members of the "Plan for Hospital Care, Inc."

Fairfield County has continued the plan of joint meetings with the city societies during the winter months. The meetings have been well attended, indicating a progressive spirit.

In closing I wish to thank the Council for their cooperation, to express to Hartford County our appreciation of the guidance and help which their Councilor, H. Gildersleeve Jarvis, gave to us during his entire time of service on the Council.

Respectfully submitted,

JAMES DOUGLAS GOLD

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#### REPORT OF THE EXECUTIVE SECRETARY

If you remember the reports of the Secretary for the last two years, you will recall that they have been rather brief, containing the merest outline of the activities of the Society's office and statistical report of the Society's membership. This brevity has been deliberate and based upon an unwillingness on my part to report on projects that were perhaps only in the formative stage or had not progressed very far. Also there was a feeling in my mind that I was serving an apprenticeship as your secretary, and until I learned more about it, it seemed wise to keep my reports in the simplest form.

Now, after three years of interesting experience and valuable observation, I feel better qualified, and so then in a sense this report is not only for the year just passed, but for that three year period.

I will review for you the progress that the Society has made and then if you will permit, I will outline for your consideration a pattern for our future development. Some of the things that the Society has done have been accomplished by officers other than your Secretary, but I will mention them here so that the whole of the Society's progress may be before you.

Three years ago we were confronted, as I have mentioned in a previous report, with a demand for increasing activity by the Society, but with an administrative organization that was incompetent to meet that demand. So we found it necessary to develop an organization, and at the same time to extend the usefulness of that organization. This was accomplished by the establishment of a full time office with appropriate clerical help, and although it will undoubtedly be necessary to further expand this administrative organization, it is now functioning smoothly and I hope efficiently, and will be capable of easy extension when need arises.

The establishment of the Society's Journal was another part of the original program of three years ago. To establish this Journal was a bold and courageous undertaking. It was organized and has been carried on outside my office with but the slightest help from me, for that reason I feel that I am privileged to speak frankly about its development. There are few among you who realize the amount of effort that has gone into the progress of the Journal, nor how easy it would have been to have it fail. The Society owes a lasting debt to Doctor Weld and his associates for bringing the Journal to its high state of excellence in so short a time, and at such a modest expense to the Society. The Journal is well thought of throughout the country and our Society should be proud of it. From time to time there have been a few members who have objected to having to take the Journal, and have asked that two dollars be deducted from their dues. This is a point of view that is somewhat difficult to explain and it is my earnest hope that as time goes on such a feeling will disappear. It is interesting to note that I have written to four members of the Society, who I was told objected to taking the Journal, and I asked them if they would suggest some ways in which the Journal might be more useful and valuable to our members. No one of the four replied. The Journal is a credit to our Society, it fulfills a very definite need and should receive the enthusiastic support of every member.

The records show that for 150 years the finances of the Society have been looked after in a thoroughly honest but somewhat sketchy fashion. I was impressed with this fact during the short time I served as the Society's Treasurer. With the increasing income and the financing of many and varied activities it became imperative that our accounting methods be improved. This has been brought about under the direction of the Treasurer with the assistance of a well known firm of public accountants, and an up to date accounting system fitted to our needs has been in operation for a year in the Secretary's office under the control of the Treasurer. Our accounts are audited by outside auditors

four times a year, and I am certain that our financial practice is now accurate and adequate and adaptable to such expansion as may later be required.

Policy making for the Society is becoming more and more complex, and although we are organized on a democratic basis, it is impossible to collect from all of our membership opinions in regard to problems that have to be answered, and policies are formed by the monthly meetings of the Council with frequent consultation by mail with members of the Council and other especially informed members of the Society. Members of the Council are faithful in their attendance at the meetings, and give freely of their time and judgment. I am grateful to them for their understanding and unflinching cooperation.

Because of our pattern of organization, the Secretaries of the eight County Associations must be relied upon for some administrative detail. I clearly realize from my background of fifteen years as a County Secretary, that these duties may be onerous, and there is a temptation not to pay much attention to the affairs of the County Association except at the time of the Association's two meetings and the end of the year, and I wish to express my appreciation to the County Secretaries for their cooperation. However, it must in all frankness be admitted that there has been occasional laxity, and I think that now the Society with an improved and constantly active central organization, may well direct its attention to lightening the administrative burdens of the County Secretaries. Care should be taken not to disturb the autonomy of the government of the County Associations, which is altogether desirable, but some of the troublesome and time consuming details may well be transferred to the office of the State Society, particularly I would suggest for your consideration some plan by which the dues to the State Society could be collected by the State Treasurer.

Further, in connection with the dues of the Society if the House of Delegates votes to accept the recommendation of the Council to increase the dues, I would like to suggest to you that members of the Society who have continued in good standing for forty years, be, upon their own request, exempt from further payment, and all their rights and privileges as members be continued.

Special problems are referred to various committees and I will briefly review for you the activities of these committees. The Committee on Public Health has a broad program, cooperating largely with Government agencies, and serving in an advisory capacity to these agencies. Under the Chairmanship of Doctor Howard, continues to be an active and productive group.

The Committee on the Clinical Congress has carried out its function in a manner that is satisfactory to all, and the members of that Committee are justly proud of the results they have accomplished. You will note a revision of the by-laws which makes this Committee one of the regular standing committees of the Society for the first time, although the Committee has been in existence for fifteen years. The funds of the Clinical Congress, will, under the by-laws which you will later vote upon, remain in the hands of that Committee, although they are funds of the Society, it appears desirable to leave those funds exclusively for the purpose originally intended.

The State Medical Examining Board is an official State body, but it is appointed by the Governor upon nomination by this Society. The problems of this Committee have increased during the last few years and it is probable that they will continue to increase. It may be that some changes in the medical practice laws of the State are desirable, and this Committee has that matter under advisement. Most of us think of this Committee as a great nuisance until we have passed our licensing examinations and then we promptly forget all about it. The fact of the matter is that these members of our Society stand as a constant safeguard of the quality of medical practice within the State. They are public servants of the highest order.

The Society's Program Committee has functioned for the first time this year, and the arrangements for the scientific program for our meeting have been ably made by Doctor Patterson and his associates. On behalf of the Society I wish to express our appreciation for their efforts.

The New Committee on Industrial Health got off to a very good start, and bids fair to become an important group in our affairs. Its activities have been somewhat retarded by the illness of the Chairman.

The Tumor Committee under the Chairmanship of Doctor Charles Larkin, who has been aided by physicians throughout the State, has done an excellent piece of work. The Report of Cancer Incidence in Connecticut prepared by the Committee has received favorable comment both here and abroad, and during the year the Society has been complimented by the American College of Surgeons on the intelligent and painstaking progress that we are making toward a solution of the ever increasing problem of malignant disease. The Committee on Hospitals has been concerned with some unusual and interesting matters. The members of this Committee were asked to serve in the conference group appointed by Governor Cross for the purpose of clarifying and preparing legislation for the regulation of prepaid hospital plans. The Society's members serving in the conference contributed largely to the success of this project. Finally legislation was written by the conference and introduced into the present General Assembly. That bill has now become a law, and prepaid hospital service plans have a legal status with adequate supervision by State authorities. It was a progressive, important and far-seeing step and the Society's Committee has made a lasting contribution to social legislation.

The Legislative Committee, for which a detailed report will be given later, has been usefully alert, and the Society is indebted to the members of that Committee for their helpful service and to Doctor Stanley Osborn, the Health Commissioner, who has been generous with his aid.

The Personnel Department of the State asked your Secretary to assist in setting up standards for employment under the merit system, and several members of the Society have been engaged from time to time in writing these standards and holding examinations for physicians seeking employment. This is an exceptionally useful service to the State, and that it was appreciated is brought out by the fact that the Director of Personnel asked the Society to appoint a Committee to make a study of conditions of employment of physicians in State Institutions. Such a Committee was appointed by the Council and consisted of Doctor Bayne-Jones, Doctor Lyman, and Doctor



Wilmar Allen. The Committee's report has been filed with the Director of Personnel and has already been discussed by the Commissioner of Finance and the institution directors. It is contemplated that this Committee will continue in an advisory capacity to the Personnel Department. It is this kind of public service which I think the Society should realize is a part of its social responsibility and be always ready to be of assistance.

Your Secretary was invited to serve as a member of a Conference Group appointed by Governor Baldwin to inquire into compulsory automobile insurance. Some of the activities of that Group are familiar to you, and in answer to the question that you may ask as to what the Committee accomplished, I think it is fair to state that the greatest accomplishment was a discouragement of badly conceived and unfortunate legislation with respect to the subject. At this time it appears unlikely that any action will be taken by the present General Assembly.

The newly authorized Committee on Public Relations has not been active, and I will later mention that field of the Society's endeavor. Publicity concerning this annual meeting and other Society activities has been handled through the Secretary's office.

Several members of the Society have served on an Advisory Board for the State Department of Education in an effort to improve the health system in the public schools. This group, although not an official Committee from the Society, has worked quietly, and the report prepared by the group is of far reaching importance.

The Society for the first time had a mid-winter meeting this year when we were privileged to entertain Doctor Irvin Abell, the President of the American Medical Association. This meeting was well attended, and I am sure that those who were there profited by the occasion. Doctor Abell was highly complimentary on the progress the Connecticut State Medical Society was making, and gave the Secretary fine encouragement. The Society may well consider, I believe, the desirability of having such a mid-winter meeting as a part of our established program.

My office has continued its efforts to develop cordial working relations with other groups interested in health activities. We have continued in close contact with the Connecticut Hospital Association, and out of this contact now comes the interesting development upon which you will have an opportunity to vote, a request from the Hospital Association that they use our Journal for the official publication of that Association. Working relationship has been instituted with the Nursing Association and with the State Mental Hygiene Society. These projects are in primary phase, but I am certain will develop to mutual advantage.

A few months ago the Council appointed a special committee to inquire into the costs of medical care for hospitalized patients. Doctor Harvey, Doctor Miller, Doctor Murdock and the Secretary were appointed to this Committee, and its study is well underway under the direction of Doctor Harvey, with the cooperation of members of the Yale School of Public Health. The results of this research will be informative and form a valuable basis for any plan for prepaid medical care.

During the past year there has been a widely prevalent public discussion of so called socialized medicine, and last

Fall it seemed likely that many lay groups would be seeking speakers to address them on the subject. Anticipating this need my office made contact with about forty Women's Clubs and Service Clubs, offering to assist them in arranging programs and discussions of the subject. The response was quite encouraging, and twelve such addresses and three radio broadcasts were presented in various parts of the State. We were not able to meet all of the requests because of a lack of speakers. Informing the public seems to me to be a considerable part of the function of the Society, and I believe we may well direct our attention to the furthering of such public service.

From this resume of our activities perhaps you will agree with me that the purposes of the Society have broadened and our usefulness increased. I hope you will agree that ahead of us lie increasing social responsibility and service. If that assumption is correct, may I suggest for your consideration certain broad proposals.

First: I believe this Society may well take the leadership in bringing together all of the groups in the State who are interested in health. Not in a consolidated organization, but through cooperative effort meet the problems that are of mutual concern. The Hospital Association, the Nurses Association, Public Health Association, Social Workers, the Mental Hygiene Society and others, all of which have a community of interest. Out of such a conference group there should come a clearer understanding of each others problems and helpful cooperation in their solution.

Second: There is an increasing public demand for methods to provide medical care for self-supporting people of modest incomes on a pre-payment basis. That this is an enterprise which the medical profession should at least explore, seems to me obvious. We have already undertaken the basic cost study. I introduced a measure before the present General Assembly that would clarify the law permitting such projects. The bill has received much favorable support and has some likelihood of passing. I recommend to you that the President of this Society be directed to appoint a Committee of five members to inquire into the subject of prepaid medical service, and if deemed practicable, submit a plan for consideration by the House of Delegates not later than the annual meeting of 1940.

Third: The forces of Government and zealous lay propaganda have excited the optimistic credulity of the people to a belief in a cheap short-cut to medical care. Medicine has done but little to counter this move and to tell the truth. Indeed, as a result of it the medical profession has been placed in a somewhat unenviable position that is not well deserved. The people of this State do not know much about the Connecticut State Medical Society, its long and enviable history, and its ideals of service, and I recommend to you that this House of Delegates direct the Society's Committee on Public Relations to enter upon a proper and dignified program of public information so that our people will know that there is a Medical Society in Connecticut, and what it stands for.

In closing let me observe that in most humans the critical faculty is more easily developed than the creative and much of criticism is born of inertia. It is easier to find

*(Continued on Page 386)*

## SPECIAL NOTICES

### BIOLOGICAL PHOTOGRAPHIC ASSOCIATION

The ninth annual Convention of the Biological Photographic Association will be held September 14-16, at the Mellon Institute for Industrial Research, Pittsburgh, Pa. The program will be of interest to scientific photographers, scientists who use photography as an aid in their work, teachers in the biological fields, technical experts and serious amateurs. It will include discussions of motion picture and still photography, photomicrography, color and monochrome films, processing, etc., all in the field of scientific illustrating. Up-to-date equipment will be shown in the technical exhibit; and the Print Salon will display the work of many of the leading biological photographers here and abroad.

The Biological Photographic Association was founded nine years ago because of the growing need for expert illustrative material for scientific research and teaching. Many workers were solving their problems in their own way. But obviously they were wasting time and effort in individually repeating experiments that had been worked out elsewhere. The B.P.A. was formed to act as a clearing house for new ideas, to pool experiences, record standard procedures and disseminate information. Its aims were scientific and all services have been volunteered by officers and members on a non-profit basis.

The B.P.A. Journal is published quarterly, constituting a volume of about 250 pages, which is furnished free to members. Membership privileges include an authoritative question and answer service; also the right to borrow loan albums and exhibits of scientific prints for study and display.

Further information about the Association and the Convention may be obtained by writing the Secretary of the Biological Photographic Association, University Office, Magee Hospital, Pittsburgh, Pennsylvania.



### INSTITUTE ON BLOOD

The University of Wisconsin Medical School is to conduct an Institute for the Consideration of the Blood and Blood-Forming Organs, September 4-6, 1939. The program is to include papers and round-table discussions by European and American workers in the field of hematology. In addition to the discussions, the following formal papers are to be presented:

Dr. L. J. Witts, Oxford, England, Anemias due to Iron Deficiency.

Dr. Cecil J. Watson, Minneapolis, The Porphyrins and Diseases of the Blood.

Dr. Cornelius P. Rhoads, New York, Aplastic Anemia.

Dr. E. Meulengracht, Copenhagen, Denmark, Some Etiological Factors in Pernicious Anemia and Related Macrocytic Anemias.

Dr. Harry Eagel, Baltimore, The Coagulation of Blood.

Dr. George R. Minot, Boston, Anemias of Nutritional Deficiency.

Dr. Russell L. Haden, Cleveland, The Nature of the Hemolytic Anemias.

Dr. Jacob Furth, New York, Experimental Leukemia.

Dr. Claude E. Forkner, New York, Monocytic Leukemia and Aleukocythemic Leukemia.

Dr. Edward B. Krumbhaar, Philadelphia, Hodgkin's Disease.

Dr. Louis K. Diamond, Boston, The Erythroblastic Anemias.

Dr. Edwin E. Osgood, Portland, Marrow Cultures.

Dr. Charles A. Doan, Columbus, The Reticulo-Endothelial System.

Prof. Hal Downey, Minneapolis, Infectious Mononucleosis.

Dr. Paul Reznikoff, New York, Polycythemia.

Physicians and others who are interested are cordially invited. A detailed program may be obtained by addressing Dr. Ovid O. Meyer, Chairman of Program Committee, University of Wisconsin Medical School, Madison, Wisconsin.



### EXAMINATIONS AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The American Board of Obstetrics and Gynecology announces that at the recent examinations held by the Board at St. Louis, Missouri, on May 13, 14, 15, and 16 two hundred and fifty-nine candidates were examined. Two hundred and twenty-eight candidates were successful in the examinations and were certified by the Board, twenty-nine candidates failed, and two examinations were not completed by the candidates.

At the annual meeting of the Board, held in St. Louis on May 12, 1939, it was found necessary, on account of increased administration expenses, to increase the application and examinations fees. Effective immediately, these are to be as follows: Application fee \$15.00, payable upon submission of application for review by Board. Examination fee \$75.00, payable upon notification to candidate of acceptance of the application and assignment for examination. Neither fee is returnable. This increase does not apply to candidates whose applications were filed prior to May 12, 1939.

The next written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, December 2, 1939, at 2:00 P.M. *The Board wishes to announce that it will hold only one Group B, Part I, examination in this and subsequent years.* Candidates who successfully complete the Part I examinations proceed automatically to the Part II examinations held later in the year.

(Continued on Page 386)



## DELEGATES FROM OTHER STATES AT ANNUAL MEETING

Delegates from other societies attending the 147th Annual Meeting of our Society in New Haven recently were as follows:—

Maine Medical Association — Eugene O'Donnell, M.D., Portland

Massachusetts Medical Society — William A. R. Chapin, M.D., Springfield, George L. Steele, M.D., Springfield

New Hampshire Medical Society — David W. Porter, M.D., Manchester, Louisa M. Norton, M.D., Concord

Medical Society of the State of New York — Terry M. Townsend, M.D., New York City  
Rhode Island Medical Society — John W. Helfrich, M.D., Westerly

Medical Society of New Jersey — Herbert W. Nafey, M.D., New Brunswick, Watson B. Morris, M.D., Springfield

Connecticut State Dental Association — C. W. Vivian, D.D.S., New Britain, B. H. Allen, D.D.S., Hartford

Connecticut Pharmaceutical Association — John J. Dugan, New Haven

In addition to the official delegates physicians also were present from Detroit, Michigan; Framingham, Massachusetts; Pullman, Washington; Brighton, Massachusetts; Laconia, New Jersey; New York City; Trenton, New Jersey; La Junta, Colorado; Oxford, England; Washington, D.C. and Philadelphia, Pennsylvania.



## WHAT ARE THE MAJOR HEALTH PROBLEMS OF TODAY?

Certain diseases have well-nigh disappeared, Typhoid, a significant source of income to the older practitioner, has become almost a medical curiosity. In a still prior generation smallpox was forced almost out of existence. Recent nation-wide crusades against diphtheria have been so effective that its presence is considered a disgrace by any municipality. Tuberculosis has retreated gradually, though it still is far from being conquered, and even pneumonia is beginning to yield to the onslaughts of scientific medicine. The present belated general crusade against syphilis can be expected to yield similarly gratifying results.

Though there is real cause for rejoicing in these results of organized campaigns against

the infectious diseases, it is somewhat depressing to note that little progress has been made against the degenerative, non-infectious diseases. Arteriosclerosis, especially of the coronary, renal, and peripheral systems; hypertension, cancer, diabetes, — these all are showing a relatively huge mortality, and life expectancy after 40 is diminishing rather than increasing. Research, from a number of reliable sources, is yielding some enlightening facts regarding the cause of these life-shortening disorders.

At least three faults in the practices of John Q. Public seem to be inculcated as factors in this increase of physical deterioration. These are overnutrition, excessive use of tobacco, and high-pressure living. Certain dietary deficiencies may be a fourth, but of this we now can speak with less assurance.

The studies of Dublin (1) have demonstrated the great importance of overweight in causing increased mortality. Diabetes and cardio-renal-vascular diseases predominated in his analysis of 192,000 cases. It is said that diabetes increases with age only in the obese, and that 80 per cent of diabetes begins with obesity (2). Short and Johnson (3) recently reported a series of 541 obese cases studied by the glucose tolerance test which showed an alarming tendency toward diabetes.

There is a marked elevation in the metabolic rate in obesity also which well may be compared to a boiler constantly being compelled to operate under forced draft. There is good evidence to indicate that over-nutrition in itself produces a disturbed endocrine balance. This is contrary to the frequent assumption that endocrine imbalance is necessarily the cause of obesity. Certain it is that the muscle and other vital tissues essential to life have an increased rate of energy exchange. This increased energy exchange usually is proportioned to the degree of obesity and probably is regulated by the endocrines. Fat produces little or no energy per se and thus should be regarded as a parasite which derives its heat, nutrition, and transportation at the expense of other structures.

Evidence continues to accumulate to prove that most cases of obesity are due to simple over-nutrition. The body has a system of "checks and balances" which tends to bring caloric intake

(Continued on Page 388)

• OBITUARIES •

THOMAS H. WELDON, M.D.  
1861-1939

Dr. Thomas H. Weldon was born in the Oakland District of Manchester, March 19, 1861.

After attending the Oakland and Ninth District Schools in Manchester, he attended Hartford Public High, graduating from that School in 1880. His medical education was received in New York University and his senior year was spent in the New York Alms House and Work House at Blackwell's Island, where he was Resident Physician. After spending two years at Bellevue Hospital in New York as an interne, he returned to Manchester to engage in the general practice of medicine in the year 1885.

With growth of his practice, he also entered politics and in 1903-04 was First Selectman, again in 1917 he was elected on the Board of Selectman, serving to 1923.

He was a member of many social and medical organizations and on the original Manchester Memorial Hospital staff, resigning in 1920 to devote his time to private practice. He was in active practice up until illness forced him to retire one year before his death May 21, 1939.

The loss of his wife and only son about four years ago weighed heavily on his shoulders and, although he was survived by six daughters with whom he made his home, his interests in local affairs became less in the last few years.

That Thomas H. Weldon lived and personified the life of a true doctor cannot be denied. He saw the great growth of medicine, the new discoveries and the dread diseases, no longer dreadful but wiped away as if by the hand of magic. He bore his burden of the horse and buggy age, the long hours on the road and the longer hours when sleep was denied him, without a murmur.

Why — because he was a doctor. He showed this both by his erect figure, manner of walk and quickness of speech and most of all because of his great faithfulness to his patients in their time of need. He was not always thinking of finan-

cial gain or the urge to condemn a fellow practitioner. The helpful hand was always extended and there were always the Christmas baskets donated to the poor, this done even when his own health was impaired and his own family troubles weighed him down with grief.

The Town of Manchester lost in the death of Dr. Weldon a great and generous benefactor, especially to those of the older generation who only looked forward to his expectant visit in order to make them well. The medical profession lost a truly great general practitioner and friend, and his family a beloved father.

As it is true, we all must die and to die when one's earthly work is as complete as was that of Thomas H. Weldon, makes such a death a memorial that others hope to achieve.

Mortimer E. Moriarty, M.D.

• Quarto Notes •

PRINCIPLES OF HEMATOLOGY  
by  
Russell L. Hayden, M.A., M.D.  
Chief of the Medical Division of the Cleveland Clinic

348 pages	155 illustrations	\$4.50
Philadelphia	Lea & Febiger	1939

The diagnosis of a blood dyscrasia is not a simple and rapid procedure. Formerly the doctor was satisfied to have the history and examination of the patient together with the blood counts and a glance at the stained smear in making a diagnosis. Oftentimes an incorrect diagnosis was made because of the lack of further studies, which are not too difficult or complicated.

The author recommends the following tests in every case: — (1) Red cell count (2) Hematocrit (3) Hemoglobin (4) Calculation of indices (5) White cell count (6) Study of the blood film (7) Reticulocyte count (8) Bile pigment. He recommends the following tests in special cases: — (1) Schilling count (2) Oxidase stain (3) Diameter and thickness of the erythrocytes (4) Fragility (5) Platelet count (6) Clot retraction (7) Coagulation time (8) Bleeding time (9) Blood volume.

The best methods are clearly described and the details necessary for the preparation are given. The mechanism of the blood dyscrasias are then discussed in detail, followed by the treatment of each disorder.



Case histories are given illustrating each type of anemia on the basis of the method of production, divided into the first group due to increased blood loss and the second group due to decreased blood formation. Finally in greater detail the laboratory classification of the dyscrasias are described with case histories. These include the macrocytic and microcytic anemias, leukemias, and so forth.

The text is admirably illustrated. Many photomicrographs, charts and drawings are original with Dr. Hayden and emphasize the years of extensive and practical work he has done in this field of medicine.

This complete and concise volume on hematology is highly recommended to the practicing physician.

W. C. Townsend



## PERSONAL AND COMMUNITY HEALTH

by

C. E. Turner, A. M., Sc.D., Dr. P.H.  
Professor of Biology and Public Health,  
Mass. Institute of Technology

625 pages                      5th edition                      \$3.00  
St. Louis                      C. V. Mosby Co.                      1939

This is the Fifth Edition of a valuable book by a recognized authority in the field of public health. The author has had wide teaching experience and thorough training in the biological sciences. The book is especially suited to the various groups of college level, and should serve as an excellent text and reference book for teachers, university students, graduate students, student nurses, and others. The material is scientifically sound, and is presented in a simple, straightforward, and readable style.

The contents cover a wide range of subjects concerned with personal and community health. The basic principles of heredity are outlined, and the role they play in the life of the individual and the race is discussed. There are chapters concerned with the anatomy and physiology of the human body. The relation of abnormal functioning of the organism to disease is considered. The chapters on persona, hygiene are intelligently written.

The first part of the book is concerned with the individual; the second part deals with community hygiene. The important environmental factors affecting health and welfare are discussed. There are chapters on Communicable Disease Control, Immunity, Maternal and Child Hygiene, School Hygiene, Public Health Administration, Food, Water Sewage, Ventilation, and Industrial Hygiene.

The subject material of the book covers such a broad field that it is not strange that occasionally a statement is made which might be misleading. For example, on page 363 under "Home Treatment" of tuberculous patients, it is stated that, "There are often disadvantages in removing the patient from his home, and it is fortunate that so much can be done by home treatment, if it is properly carried out." Such a statement might encourage the patient to remain at home. Also, physicians working in this field feel that every case of tuberculosis would profit by at least a short period in a sanatorium.

Again on page 362 the statement is made that, "The laboratory examination of the sputum will reveal the presence of the bacteria in active disease." This statement

is not entirely true, for many cases of active pulmonary tuberculosis do not show the presence of tubercle bacilli in the sputum by the ordinary laboratory procedures. The last statement in the section on tuberculosis might be questioned. It reads as follows: "That one of the most important recent activities of tuberculosis associations is the work for the detection and treatment of the childhood type of tuberculosis." This is not considered true by many persons, and such an outstanding authority as J. Arthur Meyers, M.D., concludes\*, "Our studies have led us to look on the X-ray films of chests of children as almost a total waste as far as tuberculosis is concerned."

It is felt that those persons interested in public health education will consider Professor Turner's book a real contribution to the teaching profession. It contains that basic information concerning personal and community hygiene which every educated man and woman should have. The application of this knowledge will help persons to meet their health responsibilities as individuals and as members of society.

B. G. Horning

\*J.A.M.A., vol. 112; No. 19; pg. 1910



## ORTHOPEDIC APPLIANCES

Henry H. Jordan

412 pages                      \$4.00  
New York                      Oxford Med. Pub.                      1939

This practical monograph on the principles and practice of brace construction comes at a rather interesting time. With a tendency on the part of orthopedic surgeons to invent new mechanical appliances for each situation that arises, such a reiteration of basic principles cannot avoid deflation and will keep the specialist steady on both feet. Because, who has not discovered a new method, a new apparatus or propounded a new theory only to find that he has re-discovered and not actually startled the world. Most of us after all cannot "invent gun powder" but we can appreciate sound statements of good principles.

Much of this monograph is based on a single worker's experience and conveys a somewhat limited viewpoint. However, chapters on plaster of paris technique, spinal braces, leg braces and foot braces are all set forth in simplified terms with drawings, plates and mechanical construction specifications so that the principles involved are reinforced, made to teach the reader by pleasant easy stages of reading. The one actually new approach to these multiple problems rests in the author's way of fitting appliances by means of roentgen ray, studies before and after application. He proves unwittingly the slight comparative value of spinal braces for correction of scoliosis. Lateral plates of feet in shoes, however, are more valuable in proving the efficacy of correction applied.

This is all very well but nevertheless such a study belongs in our working library. Too many monographs are purely theoretical so one that is stimulatingly practical is particularly welcome today. Once more the reviewer wishes to state that "monographs" are invaluable while "systems" are memorials, generally out of date by the time they are published. Put this one within your reach and be sure your bracemaker owns one.

C. W. Goff

WHAT IT MEANS TO BE A DOCTOR

by  
Dwight Anderson

87 pages      Cloth \$1.00      Paper 25 cents  
New York    Public Relations Bureau, Medical      1939  
Society of the State of New York

The author has performed an excellent service in presenting to the laity a picture of just what goes into a doctor's life, — his education, his training, his years of experience and the standards set for himself in medical practice. Knowing the contacts the author has had with leaders of our profession in a neighboring state it is not surprising that he can present the picture so clearly and convincingly. The source of some of the author's information, the questionnaire, is being worn threadbare; he is to be congratulated on such a hearty response to his appeal.

Should you wish a compact little volume to hand to a friend, possibly a patient, who may be desirous of being better informed about his doctor, Dwight Anderson has prepared it for you. Do not make the mistake of offering it to your son, however, for instead of helping him decide what shall be his chosen field it may but add to his confusion.



SUPRAVENTRICULAR TACHYCARDIAS

(Continued from Page 350)

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EDUCATION IN TUBERCULOSIS CONTROL

(Continued from Page 360)

<i>Second Test Strength</i>	
Total number tested . . . . .	1,951
Positive . . . . .	367
Negative . . . . .	1,584
Percentage pos. . . . .	18.8
(Of the 3,200 tested, 297 refused second test)	
Total number tested . . . . .	3,200
Total number found positive . . . . .	1,219
Percentage found positive . . . . .	38.0
<i>Males</i>	
Total number tested . . . . .	1,875
Total number found positive . . . . .	720
Percentage found positive . . . . .	38.3
<i>Females</i>	
Total number tested . . . . .	1,325
Total number found positive . . . . .	499
Percentage found positive . . . . .	37.6

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Positive.....	612
Negative.....	1,688
Percentage positive.....	26.6

*Second Test*

Total number tested.....	1,664
Positive.....	174
Negative.....	1,490
Percentage positive.....	10.3
Total number tested.....	2,300
Total number found positive.....	786
Percentage found positive.....	34.1

*Males*

Total number tested.....	846
Total number found positive.....	306
Percentage found positive.....	36.1

*Females*

Total number tested.....	1,454
Total number found positive.....	480
Percentage found positive.....	33.0



**SCARLET FEVER TREATED WITH  
SULPHANILAMIDE**

(Continued from Page 353)

have been largely obviated by the use of the less toxic neoprontosil.

3. Rectal administration of neo-prontosil in suppository form (with cocoa-butter) was effectual. Rectal administration was reserved for the markedly toxic and debilitated as well as for those suffering from persistent emesis. Occasional expulsion of the suppository in the very young may be encountered, but can be overcome. Blood and urine concentrations achieved by rectal administration of neo-prontosil were equal to those obtained by oral administration.

4. We are of the opinion that in order to reduce the incidence of septic complications, sulphanilamide therapy must be continued for a period sufficiently long, namely an average of 7 to 8 days.

5. Scarlatinal anti-toxin should still be administered to those cases where sulphanilamide is contraindicated or where satisfactory response in combatting a marked toxemia is not forthcoming.

6. Meat and eggs may be administered after

the first week of illness without untoward results.

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**PROCEEDINGS—HOUSE OF DELEGATES**

(Continued from Page 386)

fault than to remedy it, but no enterprise will thrive on criticism alone, and I am firm in my belief that we are intelligent enough and ambitious enough to make this Society a great force for public good.

There are now 1762 members of the Society. It is the largest membership that has ever been reported, and a larger proportion of the eligible physicians in the State belong to the Society than ever before.

Respectfully submitted,

CREIGHTON BARKER

(To be continued)

**SPECIAL NOTICES**

(Continued from Page 381)

Applications for admission to Group B, Part I, examinations must be on file in the Secretary's office not later than October 4, 1939.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting in Atlantic City, N. J., on June 7, 8, and 9, 1940, immediately prior to the annual meeting of the American Medical Association to be held in New York City from June 10 to 14, inclusive.

Applications for admission to Group A, Part II examinations must be on file in the Secretary's office not later than March 15, 1940.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

## STUDIES IN CONVULSANT THERAPY

(Continued from Page 344)

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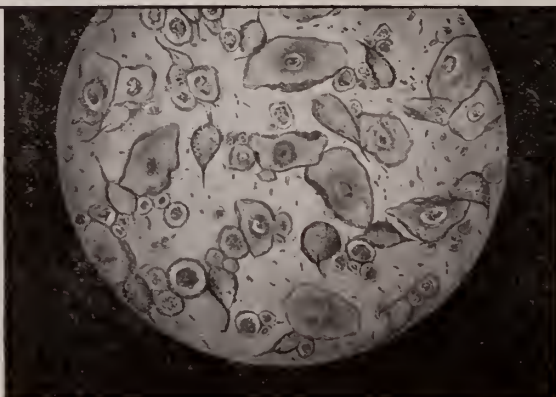
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### WHAT ARE THE MAJOR HEALTH PROBLEMS

*(Concluded from Page 382)*

and energy expenditure into equilibrium and to result in a stationary weight. It is true, however, that a continual stepping up food intake beyond that necessary to maintain a stationary weight may and does result in further weight increase.

There seems to be almost no limit to the size that may be obtained. Weights in excess of 700 pounds have been known. Conversely, there apparently is no limit to the amount by which weight may be reduced without the production of impaired health. A weight loss of 239 pounds from 395 to 156 pounds, was reported recently. (4). Although obesity can be corrected, how much better it would be if by a general program of education the public could be taught to avoid its evil consequences by curtailment at its inception. A marked increase in the average life span undoubtedly would be a natural sequence.

#### BIBLIOGRAPHY

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Proc. Life Ext. Examiners  
Mar.-Apr., 1939



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### LEDERLE AT THE NEW YORK WORLD'S FAIR

In the Medicine and Public Health Building, New York World's Fair, Lederle Laboratories are sponsoring the scientific exhibits on Allergy and on Pneumonia, each exhibit being controlled by a committee of eminent specialists on these diseases. All exhibits in the building are scientific in character, merely carrying on a small plaque the names of the sponsors.

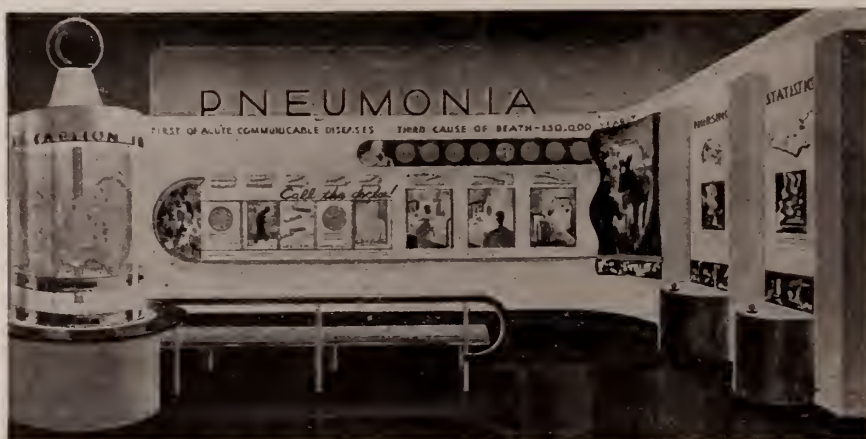
The Pneumonia exhibit, surfaced entirely of white laminated "Beetle," occupies a booth 20 x 30 feet in a commanding position. It presents, pictorially, the best composite opinion of the medical profession on how a pneumonia case should be treated. The narrative is unfolded by means of a sequence of dioramas, pictures, and charts. The story begins with an 'animation' of a man walking in the rain, and takes him through typing and serum therapy and all the various progressive stages of a typical case of pneumonia to a final picture at the serum farm where his little daughter is pictured saying, "Thanks, old

horse, you saved my Daddy's life!" A "Post-script" deals with sulfapyridine.

The second exhibit, on Allergy, tells, in changing dramatic sequences, three 2 minute dramas of Allergy: "Tommy Todd's Autumn 'Colds'", "Mrs. Tucker's Wheezes" and "Baby Bing's Eczema."

By means of an animated question box and dioramas showing typical scenes in the doctor's office, a search for the offending allergic excitant in each of the three stories is conducted through information obtained by questions, scratch tests and an examination of the patient's family tree. An interesting part of the allergy exhibit is an illuminated transparency chart showing in full color, 48 of the most common allergic excitants. A separate series of little pictures invites the visitor to examine commonplace scenes for causes of allergy and then, by pressing buttons, to illuminate the concealed answers.

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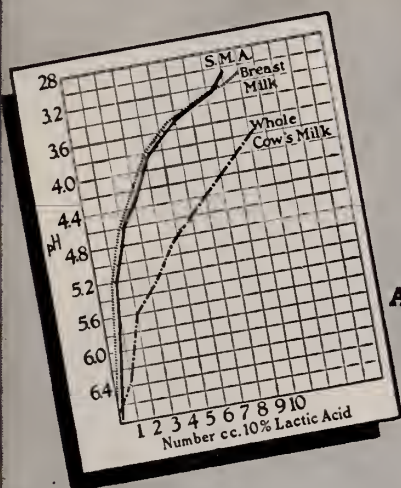


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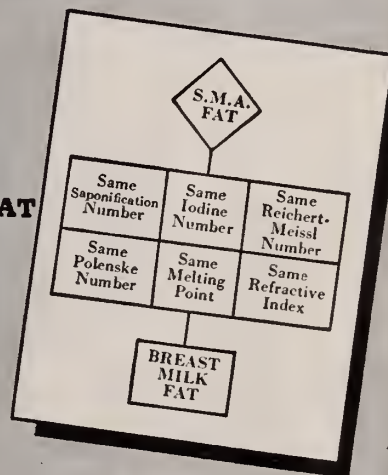
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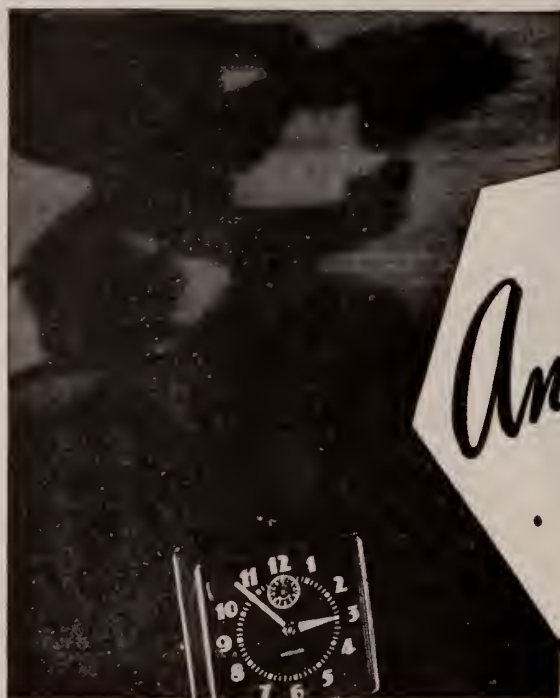
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- ☐ Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245—"Pharmacology of Inflammation: III. Influence of Hygroscopic Agents on Irritation From Cigarette Smoke."
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- ☐ Laryngoscope, 1935, XLV, No. 2, 149-154—"Some Clinical Observations on the Influence of Certain Hygroscopic Agents in Cigarettes."
- ☐ Laryngoscope, 1937, XLVII, 58-60—"Further Clinical Observations on the Influence of Hygroscopic Agents in Cigarettes."

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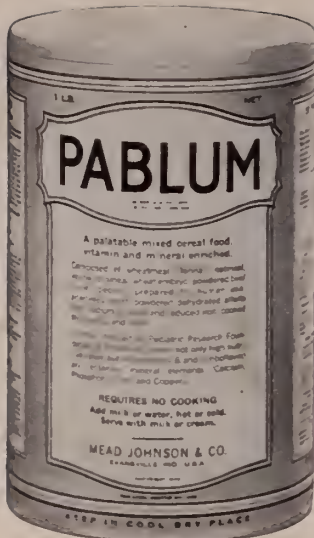
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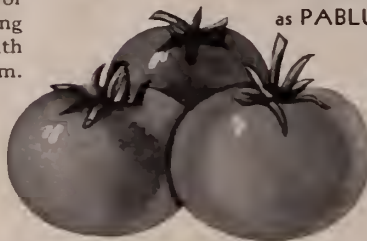
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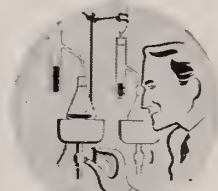
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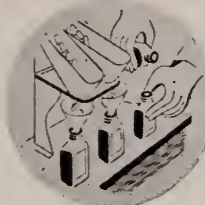


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# JOURNAL of The Connecticut State Medical Society

Owned and Published Monthly by  
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Editor-in-Chief - STANLEY B. WELD, M.D.,  
54 Church Street, Hartford, Connecticut

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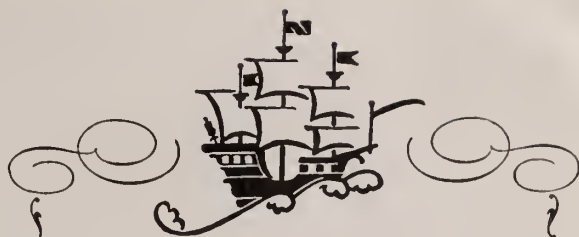
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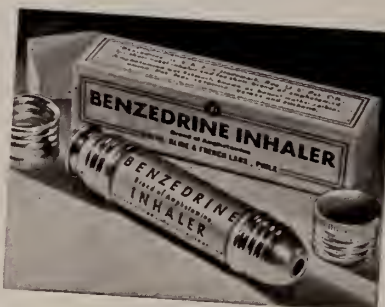
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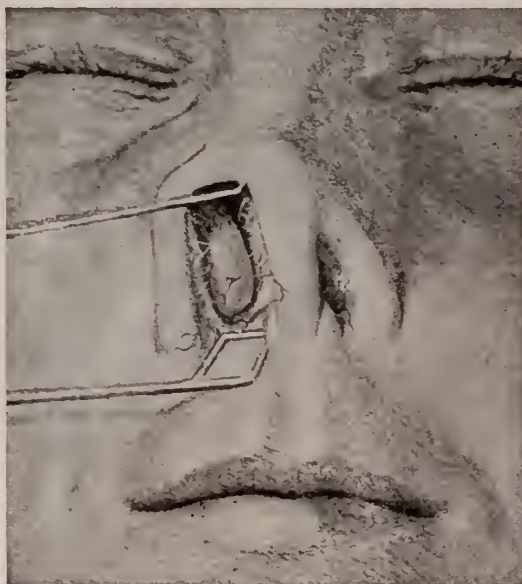
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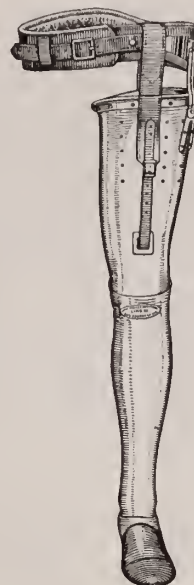
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\*\* Huffman, J. W., *Amer. Jl. Surgery*, Nov., 1935.  
Zener, F. B., *Northwest Medicine*, Jan., 1937.



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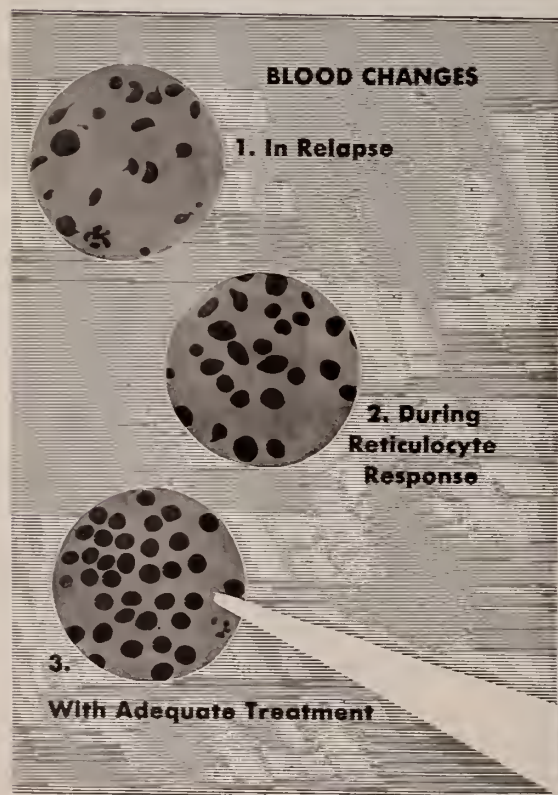
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# JOURNAL of The Connecticut State Medical Society

VOL. III.

AUGUST, 1939

No. 8

## 15th Clinical Congress Program

*(All times given are daylight saving time)*

**TUESDAY, SEPTEMBER 19, 1939**  
**Auditorium Sterling Law Buildings**  
Dr. Stanhope Bayne-Jones, Presiding

**9:30 A.M.**

### **Problems in Clinical Medicine that respond to a Psychiatric Approach.**

Dr. James H. Wall, Assistant Professor of Clinical Psychiatry, Cornell University Medical College; Assistant Medical Director New York Hospital, Westchester Division, New York City.

**10:15 A.M.**

### **Emergency Handling of Fractures.**

Dr. Clay Ray Murray, Associate Professor of Surgery, College of Physicians and Surgeons, Columbia University; Associate Attending Surgeon, Presbyterian Hospital Fracture Service and Vanderbilt Clinic, New York City.

**11:00 A.M.**

### **Clinical Problems in the Newborn Infant.**

Dr. Harry H. Gordon, Associate in Pediatrics, Cornell University Medical College; Medical Officer, U. S. Children's Bureau, New York City.

**11:45 A.M.**

### **FIVE MINUTE TALKS**

#### **What is Renal Clearance?**

Dr. Robert W. Clarke.

#### **Focal Infection.**

Dr. John R. Paul.

#### **Cerebral Regulation of Autonomic Function.**

Dr. John F. Fulton.

#### **Modes of Transmission of Poliomyelitis Virus.**

Dr. James D. Trask.

#### **Dilantin In Epilepsy.**

Dr. James C. Fox, Jr.

#### **Virus Pneumonia.**

Dr. Stanhope Bayne-Jones.

**2:30 P.M.**

### **Panel Discussions**

#### **Symposium on Medical Progress in 1939**

Dr. Louis H. Nahum, Chairman.

#### **Symposium on Surgical Progress in 1939**

Dr. Samuel C. Harvey, Chairman.

**WEDNESDAY, SEPTEMBER 20, 1939**

**Auditorium, Sterling Law Buildings**

Dr. Joseph I. Linde, Presiding

**9:30 A.M.**

### **Problems in the Etiology of Cancer**

Dr. W. E. Gye, Director, Imperial Cancer Research Fund, London, England.

**10:15 A.M.**

### **The Relation of Pain Relieving Drugs to Respiratory Morbidity.**

Dr. Ralph M. Waters, Professor of Anesthesia, University of Wisconsin Medical School, Madison, Wisconsin.

**11:00 A.M.**

### **Newer Sulfanilimide Drugs — Recent Advances in Chemotherapy.**

Dr. Joseph Millett, Junior Attending Surgeon, Nassau County Public General Hospital, Hempstead, Long Island.

**11:45 A.M.**

### **FIVE MINUTE TALKS**

#### **Use of Sulfanilimide in Gonococcus Arthritis and Salpingitis.**

Dr. Robert M. Lewis.

#### **Kidney Function, Adrenal Insufficiency.**

Dr. Daniel C. Darrow.

#### **Treatment of the Unconscious Patient.**

Dr. Richard C. Buckley



**What is A Neuro-Surgical Emergency?**

Dr. William J. German.

**Pneumo-Myelography in The Diagnosis of Spinal Cord Lesions.**

Dr. Bernard S. Brody.

**Some Aspects of Estrogens in Experimental Carcinogenesis.**

Dr. William U. Gardner.

**2:30 P.M.****PANEL DISCUSSIONS****Symposium on Modern Anesthesia.**

Dr. Edward J. Ottenheimer, Chairman

**Symposium on Drug Toxicity.**

Dr. Arthur J. Geiger, Chairman

**Women's Medical Society of Connecticut.**

Program to be announced.

**8:15 P.M.****SECTION MEETINGS****Section on Neurology and Psychiatry.****Migraine and its Treatment**

Dr. Harold G. Wolff, New York City

**Section on Dermatology and Syphilology.****Common Fungous Diseases Affecting Man**

Dr. Joseph G. Hopkins, New York City

**Hezekiah Beardsley Pediatric Club.****Prognosis of Tuberculosis in Infants and Children**

Dr. Edith M. Lincoln.

**Section on Physical Therapy.**

Program to be announced.

**Section on Radiology.**

Program to be announced.

THURSDAY, SEPTEMBER 21, 1939

Auditorium, Sterling Law Buildings

Dr. Arthur B. Landry, Presiding

**9:30 A.M.****Industrial Poison.**

Dr. George H. Gehrman, Medical Director, E. I. DuPont de Nemours &amp; Company, Wilmington, Delaware.

**10:15 A.M.****Gall Bladder Disease. To Operate or not to Operate. With Particular Reference to Acute Cholecystitis.**

Dr. Henry W. Cave, Attending Surgeon, Roosevelt Hospital, New York City.

**11:00 A.M.****The Examining Boards in the Various Specialties**

Dr. Paul Titus, Secretary of the Advisory Board for Medical Specialties, and of the American Board of Obstetrics and Gynecology, Pittsburg, Pennsylvania

**11:15 A.M.****FIVE MINUTE TALKS****Diseased Cervix as Causing Symptoms in Women**

Dr. Harlan B. Perrins.

**Cause of Delay Between Time When Cancer Patient Sees Doctor and When Patient Receives Adequate Treatment.**

Dr. F. Brae Rafferty.

**Child Guidance.**

Dr. George K. Pratt.

**Treatment of Nervous Disorders Due to Vitamin Deficiency.**

Dr. Edwin F. Gildea.

**Problems Relating to Diphtheria Toxoid Immunization.**

Dr. Maurice M. Hillman.

**2:30 P.M.****PANEL DISCUSSIONS****Symposium on Industrial Poisons.**

Dr. Yandell Henderson, Chairman.

**Symposium on Obstetrics.**

Dr. Carl E. Johnson, Chairman.

**Symposium on the Normal and Pathological Gall Bladder with its Dependent Biliary Ducts.**

Dr. Paul W. Vestal, Chairman.

**THREE DAY COURSES**

September 19, 20, 21

**Endocrinology.****Cancer.****Neo Natal Pediatrics****Problems in Clinical Medicine Encountered by the Psychiatrist.****Fracture Treatment.**

# Diagnostic and Therapeutic Per-Oral Endoscopy\*

NORTON CANFIELD, M.D.

New Haven, Conn.

With the rapid technical advance during the past twenty-five years, the lighted speculum for examination of the bronchi, esophagus and stomach now has a place in many branches of medicine. Improvement in diagnosis and additional therapeutic procedures are the two claims to attention which these methods possess. If they are to offer the full benefit of their worth, they must be available to the general practitioner in various centers not too far distant, and the endoscopist must be able to make accurate observation and interpret his findings to the practitioner. I am interested, therefore, in presenting a short summary of the possibilities of endoscopy with always a critical recognition of the limitations of our present technique.

Inspection beyond the vocal cords into the trachea, bronchi and lungs, beyond the hypopharynx into the esophagus and stomach is a logical extension of the technique of the laryngologist. But, below the larynx and below the cricopharyngeus muscle we enter a large body cavity in which are located the vital heart and lungs, and about which the laryngologist's knowledge is limited. The implication then is clear. Anatomy and physiology must be reviewed and carefully considered when examinations or treatments are contemplated. Diseases of the trachea and bronchi affect the entire respiratory mechanism. Diseases of the esophagus affect all thoracic tissues and organs. To assume the role of an endoscopist is to assume special knowledge of all thoracic functions, for in these days a mere listing of ocular findings is not sufficient for a proper interpretive consultation. Much emphasis has been placed on what is seen and not enough on its interpretation. The whole field of respiratory physiology has been revised since the inside of the lungs can be directly inspected. With the new instruments of Frenckner the individual lung capacities can now be measured, a matter of necessity when the

major pulmonary surgery in doubtful cases is attempted.

The dramatic and spectacular removal of foreign bodies has been the impetus for further investigation. The medical and lay press have well-covered this branch of our subject, and I wish only to mention it here. It constitutes an important part of endoscopy but now a very small part. Other diseases of the trachea, bronchi, lungs and esophagus have so attracted our attention that foreign body cases now constitute only about 10% to 15% of all those which should be considered in our present discussion. Let me mention, however, that an unsuspected foreign body may be the etiologic factor in pulmonary suppuration. In this regard I should like to give you a short summary of two cases which will illustrate.

A two year old boy was admitted to the New Haven Hospital on August 1, 1935 with a chief complaint of cough, fever and dyspnea for a period of two days. The admission diagnosis was pneumonia and a careful history revealed nothing which would make one suspect the presence of a foreign body. Roentgenograms of the lungs showed an atelectasis of the left lower lobe. This was considered adequate evidence of obstruction to the left main bronchus, and bronchoscopy on the day of admission demonstrated a left main bronchus which was completely plugged with what appeared to be roots of grass. These were removed and the left main bronchus below the obstruction was aspirated. After the procedure history was obtained to the effect that this child had been on the lawn when his father had been cutting the grass some three days before, and probably he had pulled up some grass and aspirated the roots. In one week the chest was clear and his recovery was uneventful.

Another case of unsuspected foreign body is represented by a forty-two year old woman, who was admitted to the New Haven Hospital on August 26, 1933. Her chief complaint was cough for a period of nine months with gradually increasing sputum. There was definite history of "swallowing" a bone before the present illness, but x-rays which had been taken did not demonstrate an opaque foreign body. The sputum was foul and bronchoscopy a few days after admission demonstrated a piece of beef bone in the right main bronchus about 6 cm below the bifurcation. The bone was easily removed and her recovery

\*From the Division of Otolaryngology, Department of Surgery, Yale School of Medicine.



during the next two months was uneventful. Two years later she was asymptomatic. The bone was so placed that its shadow by roentgenogram was obscured by that of the mediastinum.

Now, let us consider the other 85% to 90% of cases to which the endoscopes are now applied to advantage. These will be considered under six groups.

**Bronchoscopy for Diagnosis:** Jackson has said that the bronchoscope should always be used when other methods fail to reveal the exact diagnosis, but since the procedure is not always available for the practitioner, this dictum should be changed to state that the bronchoscope may give additional information and should be used if a different diagnosis would change the course of therapy.

We have all seen patients in a condition where an added manipulative procedure is contraindicated. Expense is frequently an item and the procedures are still such that they cannot be done in difficult cases except in medical centers where adequate help is available and emergency after-care is at hand. But in the puzzling cases which do not recover or have progressed to chronic suppuration, the examination can be carefully planned and when the roentgenologist, the practitioner and the bronchoscopist can consult together, diagnoses and therapeutic programs may be determined. Specifically, cases of chronic cough with or without sputum which do not respond to the usual treatment; patients with tuberculosis where the periphery of the lung is clear but the sputum remains positive for the bacillus; hemoptoses of unknown etiology can be bronchoscoped and many diagnoses can be cleared.

Cancer of the lung is on the marked absolute increase within the past ten years and here biopsy plays a most important role. To be sure, treatment of such a lesion is of often little avail, but the patient must be considered. His family must have a prognosis, and, although the patient is doomed, his care to the end is as important as that of any other patient. About 60% of the bronchial carcinomas arise in the main bronchus below the bifurcation well within the range of the bronchoscope.

Our patient, L. C., a twenty-seven year old woman, was admitted to the New Haven Hospital on December 26, 1933 with a chief complaint of pain in the left chest and cough. Roentgenogram demonstrated a shadow to the left of the heart and diagnostic bronchoscopy was advised.

A biopsy was taken and a malignant neoplasm of a rapidly growing type was discovered. One month later exploratory thoracotomy demonstrated the tumor to be growing through the tissues of the mediastinum and consequently not removable. Roentgen-irradiation was applied with some improvement but the tumor could not be eliminated by this method. The patient gradually became worse, six months later the x-rays showed a marked increase in the size of the shadow. By means of the bronchoscope the diagnosis of this case was made and prognosis for the patient's family was determined.

The adeno-carcinomas, which occur in the bronchial mucosa, are radio-sensitive and much improvement has been obtained in some of these cases by the implantation of radium.

Our second group of cases are those who deserve bronchoscopic therapy. The most common lesions are benign stricture, acute atelectasis and chronic pulmonary suppuration. Every major insult to the tracheo-bronchial tree results in scar tissue. Scar tissue contracts and the lumen is diminished. Here dilatation of the airway is of service. A specific case will illustrate.

A fifty-seven year old male was admitted on October 18, 1935 with a chief complaint of cough for four months. Tuberculosis had been eliminated, pneumo-thorax was of no value in eliminating the cough because of the pleural adhesions. Two days after admission bronchoscopy demonstrated a collapse of the left main bronchus. The appearance of the mucous membrane was not that of a neoplasm so that it was thought wise to attempt dilation of this bronchus. At this and on three other occasions dilatation was done with marked improvement in the symptoms and a partial clearing of the lung shadow. This patient became asymptomatic by this procedure, but, of course, the fibrotic process which had occurred in the lung will never completely disappear.

Atelectasis is the most usual post-operative pulmonary complication, most frequently relieved by rebreathing carbon dioxide or by the use of the blow bottle after the anesthesia. However, occasionally these methods are of no avail. The x-ray shows a shift of the mediastinum to the affected side and a rise of the diaphragm, the temperature remains elevated, the patient looks sick. Bronchoscopic aspiration promptly relieves the condition by removing thick, inspissated, stringy mucous. This atelectasis occurs because of localized areas of bronchitis at which thick mucous collects. The anesthetic and sedatives administered diminish the cough reflex and thereby permit secretions to plug the bronchus. We have observed this sequence of events recently following a local tonsillectomy. Carbon dioxide and the encouragement of coughing were of no avail. Bronchoscopic aspiration relieved

the condition and return of the normal lung function occurred in twenty-four hours.

Chronic pulmonary suppuration occurs in several diseases, the differentiation of which is a complicated procedure, but again, the bronchoscope is of aid to the practitioner in removing specimens and aspirating from the lungs much of the foul, putrid pus. The patient is either much improved or better prepared for possible thoracic surgical interference.

Bronchoscopic aspiration of asthmatic patients has had some firm advocates, but in my experience these patients are better handled in other ways less strenuous.

Our third group includes those where bronchoscopy and esophagoscopy at the same time are indicated. Jackson has stressed the point that the anatomic relationship of the posterior wall of the trachea and the anterior wall of the esophagus is so intimate that esophageal disease may cause cough as the first symptom. When physical examination and bronchoscopy fail to reveal the cause of the cough, the esophagus must be inspected. Disease in this organ may be present before symptoms referable to the esophagus occur.

The fourth group are those in which esophagoscopy is indicated for diagnosis. Unfortunately the esophagus must be more than half occluded before symptoms occur and then the patient will usually chew his food better for a long time before he complains. The esophagus is notoriously so poorly supplied with sensory nerve fibres that pain is only a late symptom, in fact, often absent until the esophageal wall is penetrated by the disease. However, delayed swallowing function does not occur and regurgitation of food may be present. These are the chief complaints. Here the fluoroscope and roentgen ray are of extreme value in demonstrating esophageal function and often locating the exact position of the lesion. But the roentgen ray cannot diagnose the lesion with certainty. The mucosa must be seen and a biopsy is often necessary. Here again with malignant disease we have little to offer, but prognosis is to be considered and palliative treatment instituted. If malignancy can be ruled out, the esophagus can often be restored to health.

The fifth group are those where endoscopic therapy can be applied to the esophagus after the diagnosis is made. The following case will illustrate.

A twenty-five year old woman was admitted to the Hospital on June 10, 1935 with a chief complaint of dysphagia which had been present since birth. Fluids and very soft foods only could be ingested. In 1928 roentgenograms of the esophagus had been taken and a mistaken diagnosis of cardiospasm was made. No esophagoscopy was done at that time. Fluoroscopic examination of the esophagus showed a stricture at the junction of the lower and middle third. With the trickling through of a small amount of the barium mixture, a diagnosis of congenital stricture was made. Esophagoscopy confirmed this finding and dilatation of the stricture was done on four separate occasions. This permitted the ingestion of solid foods, and many months after the procedure the patient was completely asymptomatic. Further dilatations may be performed if necessary.

The diagnosis of cardiospasm depends upon the esophagoscopic findings and the roentgen ray examination. If delayed swallowing function is found to be due to a constriction of the lower end of the esophagus and the mucosa seen to be normal through the esophagoscope, dilatation with the hydrostatic bag will produce complete relief.

A fifty year old man was admitted to the Hospital on September 18, 1935 with a chief complaint of dysphagia for seventeen years. The difficulty in swallowing occurred over a short period of time and for three years he sought advice. For the next fourteen years he accepted his infirmity and was able, by storing large amounts of food and fluid in his esophagus, to maintain his nourishment. However, at any time he could voluntarily regurgitate from four to eight hundred cubic centimeters of sour esophageal fluid. The dilatation of the esophagus was so extensive that he could actually feel the fluid mass roll from one side of his chest to the other as he turned over in bed. Roentgenogram of the esophagus with barium showed enormous dilatation and a curve in the lower end of the esophagus. Three days after admission attempt at dilatation was unsuccessful because the dilating bag could not be passed into the stomach. A string was then swallowed and after two days the dilating bag was passed over the string. The stomach was easily entered and a single dilatation gave complete relief. I have communicated with this patient recently and he has had no dysphagia whatsoever since that dilatation more than three years after the procedure.

Our sixth group I shall mention briefly. During many esophagoscopies the stomach is entered and a portion of the mucosa is seen. This constituted a very inadequate exploration of that organ, but with the new Schlinder flexible gastroscope the entire inside of many stomachs can be visualized. The procedure is still in its infancy but reports recently have been most favorable. This will, again, add another diagnostic procedure to a portion of the gastrointestinal tract which had previously been inaccessible for observation. The flexible gastro-



scope is a solid instrument so that inspection of the inside of the stomach is largely limited to the visual impressions received through the lens.

In conclusion, the long, lighted speculae are valuable adjuncts to our present methods for diagnosis and treatment. They are not infallible and are not perfect, but they can, if used in cooperation with the roentgenologist and the practitioner, bring light and hope to the unfortunate patients who suffer from diseases of the thorax and upper abdomen. The present trend to master the technique includes the idea of making the service more valuable to the practitioner. As the demand for these procedures from the physicians who manage thoracic cases increases, improved methods will be forthcoming and another group of patients will be brought within the range of practical therapeutics.

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#### SULFANILAMIDE REDUCES MENINGITIS DEATH RATE

Use of sulfanilamide in the treatment of meningitis has definitely reduced the death rate from this infection, Julius M. Waghelstein, M.D., Baltimore, declares in *The Journal of the American Medical Association* for December 10.

This decrease has occurred in early adequately treated cases as well as in those severely ill, usually seen late and which generally terminate fatally within twenty-four hours.

The simplicity of sulfanilamide treatment lessens the discomfort generally suffered by the patient due directly to treatment, and its use also shortens the patient's stay in the hospital.

The fatality rate in seventy-two cases, when sulfanilamide alone was used, was 15 per cent and in the early adequately treated cases it was 12 per cent. In 1935 and 1936 the death rate among 368 patients treated with serum only was 27 per cent. In the thirty-four cases treated with sulfanilamide and antimeningococcus serum the death rate was 24 per cent, and in those cases treated early the rate was 13 per cent.

Complications due to sulfanilamide therapy were infrequent and very mild. Recurrences of the infection were reduced. However, complications due to the infection were not noticeably reduced.

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(SEE PAGE 2.)

## The Versatility of Cesarean Section\*

H. B. PERRINS, M.D., and MAX BERLOWE, M.D.,  
New Haven, Conn.

During the last twenty years Cesarean Section as a method of delivery has made tremendous strides. From a rare, spectacular and dangerous operation it has become a common, in the opinion of many, a too common proceeding, which attracts little more attention than interval appendectomy. The mortality of about 10% accepted twenty years ago has been reduced, in well managed hospitals, to that of simple laparotomies.

This situation is not without its dangers. The very fact that skilled obstetricians can, by careful selection of their cases and types of procedure perform Cesarean Section with safety, has created a sense of false security on the part of some general surgeons and general practitioners who are called upon to perform occasional Cesarean Sections. The varied indications for the newer types of procedure has greatly lowered the high mortality rate which often followed the common current practice of classical section. The occasional operators either are not trained to perform the varied procedures at the command of the trained obstetrician or do not realize their significance.

For this reason it is our desire to emphasize the importance of careful selection of the various types and the results of such selection. A careful study of the results of Cesarean Section at Grace Hospital during the past five years has been undertaken. The study has been limited to the last five years because during this time we feel that the versatility of Cesarean Section and its value has been demonstrated.

Our incidence for Cesarean Section is admittedly very high. This can be explained in two ways.

1. With the perfection of our technique in Latzko Sections our indications have been definitely widened.

2. Grace Hospital has a large number of abnormal and often neglected cases referred in by outside men and from outlying communities.

At Grace Hospital the staff organization follows closely that suggested by the American Hospital Association.

In the private pavilion major obstetrics is restricted to those known to be reasonably capable obstetricians. However, in the case of Cesarean Sections we still permit its performance by general surgeons having major operative privileges. Because of the obvious danger in this situation the following suggestions have been offered by the obstetrical department, for all cases where abdominal delivery has been decided upon.

1. Classical Cesarean Section should be restricted to elective section on patients not in labor and whose membranes are intact.

2. Laparotrachelotomy (DeLee) Cesarean Sections should be performed on clean cases in labor whose labor has not exceeded twenty-four hours and whose membranes have not been ruptured over twelve hours.

3. Latzko Cesarean Sections should be performed on clean cases in labor over twenty-four hours, on cases not grossly infected whose membranes have been ruptured over twelve hours and on those cases who have had repeated vaginal examinations.

For operators not experienced in the rather complicated technique of Latzko Section, the First operation is advised.

4. Either Porté or true Porro Section should be performed on all grossly infected cases. Ordinary hysterectomy after section is not sufficient protection on these cases. The uterus should be extra peritonealized before it is opened.

It is brought to the attention of the Staff that the consultation services of the obstetrical staff are offered (without fee when necessary) to assist in the decision as to the advisable method of delivery.

We shall make no attempt to go into detail regarding the indications for abdominal delivery in this paper. (See Journal, Vol. II, No. 10, Pages 499-501).

\*(From the Department of Obstetrics & Gynecology at Grace Hospital, New Haven, Conn.)



TABLE 1  
MORBIDITY

Total No. Cases	Service	No. Cases with 2 or more days morbidity	No. Cases with 3 or more days morbidity	Percentage 2 or more days morbidity	Percentage 3 or more days morbidity
294	Wd. & Pvt.	72	46	24.9%	15.9%
217	Pvt.	59	41	27%	18.9%
77	Ward	13	5	16%	5.1%

A minimum temperature reading of 100.4 degrees occurring for at least two days and not including the first post-operative day is taken as our standard for morbidity determinations. The incidence as noted is greater on the private side. This difference is most marked with a morbidity of three or more days. We believe that certain procedures, as done by the Staff obstetricians, are predominating factors in the decreased morbidity. These will be discussed later.

TABLE 2  
TYPE OF OPERATIVE PROCEDURES AND MORBIDITY

Operation	No. Cases	No. Cases with 2 or more days morbidity	Percentage Morbidity
DeLee	155	38	24%
Classical	102	30	29%
Latzko	26	10	38%
Porro	10	3	30%
Hirst	1	0	0

Most of the Classical type of procedures were done during the years from 1933 through 1935. Since then there has been a marked decrease in this procedure. Certain variations in the usual technique are practiced by the obstetrical staff on classical and low flap sections which we believe have a distinct bearing on morbidity.

Upon opening the peritoneal cavity the uterus is walled off laterally with a tape pad along each broad ligament and above by a small tape pad inserted in the upper angle of the wound. The uterus is then opened and the foetus delivered. Immediately upon delivery of the child the cut edges of the uterus are grasped with Allis clamps and pulled into the edge of the wound. The placenta is then allowed to separate and is expressed. By this method the excess spill into the peritoneal cavity is avoided. The uterus is then sutured without removing it from the peri-

toneal cavity. We feel that in this way we protect the peritoneum from spill and the uterus from trauma, chilling etc., incidental to its removal to outside the abdomen for suturing. We believe that excess blood spill into the peritoneal cavity increases morbidity.

The selection of the method to be used, once abdominal delivery is decided upon, follows closely the suggestions to the general surgical staff.

The first three deaths occurred during the year 1934. The last death occurred in 1936. The first death would seem to be ascribable to an error in choice of proceeding. In our opinion Latzko section should have been chosen. The other three deaths are definitely attributable to grossly inadequate prenatal care. (See Journal, Vol. II, No. 10, Pages 499-501).

Forty-nine cases were sterilized. Indications for this procedure included medical and psychiatric conditions. We also suggest sterilization in the third repeat section. Fourteen percent of these cases had a morbidity of two or more days. There were no complications in these cases. The usual method of sterilization is section of the tube and burying the proximal end in the layers of the broad ligament.

Proper credit should be given to a very efficient anesthetic service headed by Dr. B. C. Sword for the relatively low mortality in this series of cases. Anesthesia since 1934 has for the most part consisted of the administration of cyclopropane and oxygen, using the closed circle technique and when necessary frequently the intra-tracheal catheter was employed. This form of inhalation anesthesia has been varied when indicated by occasional spinal anesthesia, extra dural and parasacral block as well as occasional local infiltration with novocaine.

### Summary

1. By the careful selection of cases and the mastering of the various techniques Cesarean Section can be safely extended to many complications of pregnancy and labor.

2. This extension of indications should be rigidly restricted to the experienced obstetrician.

3. A report of five years of Cesarean Section at Grace Hospital demonstrates a wide variation of proceedings and the results thereof.

## Birth Control Issue in Waterbury

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The arrest on June 24, 1939, of two Waterbury physicians together with the investigation of the patients involved and the seizure of records and equipment of the Birth Control Clinic maintained at the H. S. Chase Memorial Dispensary in Waterbury calls attention to some of the obsolete laws remaining on the statute books and raises several questions which are of especial importance to the medical profession. According to the interpretation of the State law made by the State's Attorney.

1. The law forbids married persons in Connecticut to use contraceptive devices to help plan their families and have healthy babies at a time when they want them.

2. It forbids a married woman to use such measures prescribed by a doctor to protect her life when pregnancy would threaten it.

3. It forbids physicians the right to use the latest and most scientific information in this line in the treatment of his patients.

4. It may interfere with the confidential relationship and privacy of the patient and physician.

5. Basically, the broad issue at stake is the interference of the law with the life and liberty of the individual citizen as guaranteed by the constitutions of both the United States and the State of Connecticut.

Following the report by Mrs. A. Morgan Pease, President of the Connecticut Birth Control League, Inc., at the annual meeting in Hartford on June 6th that a birth control clinic was being held at the Chase Dispensary in Waterbury, resolutions were drawn up by the Catholic Clergy Association of Waterbury on June 10th denouncing the clinic and demanding an investigation and prosecution. June 12th, agents of the States Attorney, William B. Fitzgerald, seized the records and supplies of the clinic under a search warrant issued by Judge McEvoy. Two physicians to the clinic, Dr. William A. Goodrich, and Dr. Roger B. Nelson, both of Waterbury, and Mrs. C. C. McTernan, volunteer chairman, a former public health nurse, were

arrested on June 24th on charges of violating sections 6246 and 6562 of the general statutes of the State of Connecticut. All pleaded not guilty when arraigned before Judge Kenneth Wynne of the Superior Court of New Haven County and elected trial by jury. All three were released without bond in custody of their counsel, former States Attorney Lawrence L. Lewis.

On June 29th a demurrer was filed by J. Warren Upson, co-counsel for the defense, declaring that section 6246 of the general statute is unconstitutional in that it interferes with individual liberty of citizens of the state and constitutes deprivation of life, liberty and property without due process of law, sets no reasonably precise standards of guilt, and is not intended to apply to medical practice. On July 3rd the State offered as an exhibit the materials seized requesting an order for their destruction. The Waterbury Maternal Health Center agreed to a statement of ownership. Judge Frank P. McEvoy set the dates of July 25th and August 15th for filing of briefs by the defendant and by the State.

The arrests are considered as a test case of the law which Birth Control advocates, both lay and medical, have been attempting to have liberalized for some time.

The laws<sup>1</sup> under which the charges have been brought were enacted in the year 1879 and read as follows: Section 6246. *Use of drugs or instruments to prevent conception.* Any person who shall use any drug, medicinal article or instrument for the purpose of preventing conception shall be fined not less than fifty dollars or imprisoned not less than sixty days nor more than one year or be both fined and imprisoned. Section 6562. *Accessories.* Any person who shall assist, abet, counsel, cause, hire or command another to commit any offense may be prosecuted and punished as if he were the principal offender.

The States Attorney holds that under these laws the patients of the clinic are guilty of crime



in the use of contraceptives and doctors are guilty for prescribing their use.

Previous to the opening of the Clinic last October, patients from Waterbury were being referred to the clinics in Hartford and New Haven by the local dispensary and social agencies. The Clinic has accepted only married women as patients who could not afford to consult a physician privately and, in the opinion of their doctors, needed protection for their lives and health. In the majority of instances patients were advised free of charge. Some patients paid fees ranging from 10 cents to \$1.00 for materials. All persons connected with the clinic served voluntarily and received no compensation for services rendered. So far none of the women patients of the clinic have been arrested.

Medical opinion on the question of birth control has been more united in recent years and has been enlightened and stimulated by pioneer efforts of various lay organizations. The house of delegates of the Connecticut State Medical Society at a meeting May 21, 1931,<sup>2</sup> unanimously adopted the following resolution:

"As a medical organization the Connecticut State Medical Society is concerned solely with the medical and public health aspects of birth control and not with social or economic considerations. The present Connecticut Statutes provide for the legal performance of abortion in the presence of tuberculosis, heart disease, nephritis, and other serious diseases. With this fact in mind it appears reasonable that our patients be further safeguarded by legalizing the dissemination of contraceptive advice for medical purposes by licensed practitioners as was embodied in a proposed amendment to the State Statute which was approved by more than four hundred members of the Society and by the Judiciary Committee of the present Legislature." This statutory amendment failed of passage.

The Committee on Public Policy of the Connecticut State Medical Society in their annual meeting in 1932<sup>3</sup> reported as follows:

"If the occurrence of pregnancy in physically unsuitable mothers is legally recognized as unpreventable; if artificial medical termination of that pregnancy is legally authorized and the term "to preserve life" is fraught with risk in itself and is an added tax at a time when all stress should be avoided, then sane medical

opinion would certainly decree that prevention of such a condition (pregnancy in disease) was immeasurably superior to the corrective procedures; certainly the situation parallels immunization and prophylaxis in infectious diseases and the periodic health examination as compared to treatment after disease has become established . . . Studies of maternal mortality in Connecticut prove that approximately one quarter of our deaths arise from septic abortions; a second quarter from disease of the heart, kidneys, lungs and metabolic diseases associated with pregnancy. Thus one-half of our annual loss could be obviated by some harmless method of preventing pregnancy in such cases . . . The State Society should exert every effort to secure for physicians legal permits to exercise their proper duty to protect and procure for their patients the best possible state of health, including — when required — the prevention of conception."

In June, 1937, the American Medical Association adopted the report of the committee appointed to study contraceptive practices and related problems.<sup>4</sup>

"1. That the American Medical Association take such action as may be necessary to make clear to physicians their legal rights in relation to the use of contraceptives.

"2. That the American Medical Association undertake the investigation of materials, devices, and methods recommended or employed for the prevention of conception, with a view to determining physiologic, chemical, and biologic properties and effects, and that the results of such investigations be published for the information of the medical profession.

"3. That the Council on Medical Education and Hospitals of the American Medical Association be requested to promote thorough instruction in our medical schools with respect to the various factors pertaining to fertility and sterility, due attention being paid to their positive as well as their negative aspects."

These resolutions were also approved and enlarged upon by the sections on Nervous and Mental Diseases, and Obstetrics and Gynecology of the American Medical Association in their 1938 meeting,<sup>5</sup> recommending the alteration of existing laws so that doctors may legally give contraceptive advice to their patients. Other societies and organizations which have approved

this move are the American Gynecological Association, the American Neurological Association, Medical Women's National Association, National Committee on Maternal Health, the Committee on Maternal Welfare and the Health Committee of the League of Nations, the Chinese Medical Association, the Ministry of Health of Great Britain and numerous state and county medical societies.

Birth control is now apparently considered legal in the United States. Federal laws classed birth control with obscenity and forbid the mailing, sending by common carrier (express) or importation of contraceptive information or supplies. Mrs. Sanger organized the National Committee on Federal Legislation for Birth Control to secure an amendment to these laws, exempting physicians from their restrictions.

In November 1936, a Court Decision in a test case accomplished what had been sought through legislative action. The U. S. Circuit Court of Appeals for the Second Circuit ruled that the design of the Federal statutes "was not to prevent the importation, sale or carriage by mail of things which might intelligently be employed by conscientious and competent physicians for the purpose of saving life or promoting the well being of their patients."

Since the United States government decided NOT to carry the case to the Supreme Court, this decision becomes, in effect, the law of the land.

Although the Federal law permits the shipment of contraceptive devices into Connecticut, the Connecticut law is interpreted to prevent their use.

Birth control has won acceptance as a public health measure and a part of preventive medicine. A recent nation-wide poll by the Ladies Home Journal found that 79% of women favored it.

The State of North Carolina has made birth control information for health reasons available to all women of that state through their Department of Health.

It is unfortunate that in the newspaper and apparently the pulpit publicity of this case locally there has been the confusion of using birth control, or contraception and abortion, or termination of pregnancy synonymously, or at

least by discussing the two subjects together, of giving that impression to the general public. As a matter of fact, the term birth control is really a misnomer, as we do not attempt to control birth but really to control conception. The terms contraception, prevention, or preconceptional care are the terms of choice.<sup>6</sup>

The question of the health and well being of the women and children present and future should be primarily a medical and not a moral problem—one of preventive medicine and public health rather than a religious one and should be approached practically and sincerely with the welfare of the patient and community as the main objective.

The Connecticut law appears to have been designed to prevent all use of contraceptive devices. The position of counsel defending the accused doctors is that this Statute should be limited in application and that an exception should be read into it permitting the medical profession to prescribe the use of contraceptive devices for health reasons in cases in which they feel that contraceptive measures are indicated. There is no attempt being made to have the law construed in such a way that unmarried women, high school students, for instance, could obtain contraceptive information.

The prosecution claims that every user of a contraceptive device within the State of Connecticut is guilty of a crime for which he or she can receive the maximum penalty of one year in jail.

It does seem that the existing Statute as it is being interpreted in the pending prosecutions seriously limits the physician in the performance of his duties and that if the existing Statute is construed to have the far reaching effect claimed for it by the prosecution it should be amended.

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## The Alliance Between Great Britain and Russia\*

*(From the Special Correspondent of the Journal  
in London)*

On every side it is asked what the obstacles are between London and Moscow. The question can be very simply answered. One of the principal objects of erecting what is commonly known as the peace bloc was to save Rumania and Poland from an invasion which, according to some persons, was imminent. Both countries, however, are disinclined to be saved if the price required of them is full military collaboration with the U.S.S.R. Our most reliable reports say that if Great Britain and France persist in a determination to create such an alliance, they will both come up against a body of Polish and Rumanian opinion so powerful that the whole laboriously erected structure of "non-aggression states" will in any event be overturned. That is the view of experts who know these countries extremely well. Great pressure might produce a facade of unity and apparent willingness to compromise over the Russian question, but the great forces ruling over the destinies of Poland and Rumania will not in the final issue agree to the acceptance of full Russian military support but will rather come to terms with Berlin. If, therefore, the Russian alliance is pressed, Great Britain must be prepared for the possible defection of both Poland and Rumania.

Rumania's situation is unsatisfactory. Although she has accepted the British guarantee, she has failed to come to any understanding with Poland for mutual assistance in the event of either power — both of which are guaranteed by Great Britain — becoming the object of aggression from the West. Internal conditions are poor. The German minorities are still rather quarrelsome. French circles in Bucharest are very anxious about the progress of German penetration in the economic sphere and are somewhat suspicious of the striking similarity of political methods employed by the leaders of the Rumanian Government and those of Germany. The regime in Rumania is, of

course, of a purely Fascist character and by no stretch of imagination can it be described as democratic in spirit or in practice. The Germans are becoming more and more active in Rumania to the extent that machines formerly purchased in the United States are now being bought in Germany. The Reich has, moreover, increased her purchases of wheat from Rumania to the extent of 600,000 tons, due for delivery by July 10. Propaganda in Rumania through the activities of German agents is seeking to alienate the country from the Anglo-French-Russian military alliance.

Another consideration is that there are a considerable number of countries, the friendship and support of which is of importance to Great Britain, which, if they find that collaboration with London involves becoming directly or indirectly a part of a military system of which Russia is the principal member, will at an early date make their own terms with the Axis partners. The conclusion of an alliance with the Soviet will therefore achieve for Germany almost all that she desires at this stage without the firing of a shot or even an international crisis. It will also provide Herr Hitler with his much-needed propaganda at home.

A glance at the type of Russia's Army officers is of interest. Of the 46,000 officers of the Red Army at the beginning of 1937, only 4,500 belonged to the Old Imperial Army, 25,000 came from the Soviet Schools and 16,000 had practically no education at all. A large proportion of the officers were illiterate when they entered the Military Schools and the majority had only primary education. The last report of Marshall Touchachevsky to the Congress of the Soviets showed that only 15 per cent of the colonels and about half the senior officers had passed through Military Academies. This was of course before the purge. When Marshall Touchachevsky paid his visit to Paris it was

\*This is the first of a series of articles pertaining to the World situation.

clear to French observers that owing to the deficient education of younger officers they had little but a superficial knowledge of their profession.

As for the aircraft, the production is rather slow just now, although it is intended to speed up next year. Soviet pilots on the whole are well thought of but they lack initiative and sound judgment. Ground personnel is unsatisfactory. Russians make poor mechanics and they take very little pride in their mechanical work. The Russian has an extraordinary desire to play about his machine rather to treat it seriously.

Accurate estimates of the Navy are impossible. The Soviet Naval forces are divided into three Fleets: the Baltic, the North Sea and the Black Sea Fleets. Russia possesses about 145 submarines, many of which are modern. Not many ships in the higher tonnage classes have been built since 1918, although construction of the aircraft-carrier *Stalin* was completed in 1937. An effort is now being made and the 1938 program allows for the construction of four 8,000-ton cruisers, eight 2,895-ton destroyers and a sister ship for the *Stalin*.

Fortifications are being constructed along the Estonian, Latvian, Polish and Rumanian frontiers and it is said that the civilian population has been cleared to a depth of several miles. There is some road building going on with the purpose of improving the appalling communications. It is an ambitious program and of course must be, considering the length of the frontier concerned. In so far as Russia has a strong position it is a defensive and not an offensive one. The railway system has suffered from twenty years of overloading and the rolling stock is poor and in a very bad condition. There can be no doubt that having regard to appalling communications the outlook for a Soviet army operating in the West and for Russia's allies would be exceedingly poor.

The morale of the U.S.S.R., both military and civilian, has been greatly undermined by the 1937 and 1938 purges, when thousands of military and civil officers were shot. According to the best information there was a widespread pro-German party in the armed forces and if, under such rigid government, a plot could go so far when the risks were so terrible, then indeed there must be deep seated ill feeling somewhere and the situation must be a very

doubtful one. These facts must be taken into account.

Many experts hold the view that Russia could not stand the strain of war and that if Stalin ever dared to order complete mobilization the armed forces would be occupied not so much in dealing with Germany as with setting up a new regime in Russia. Others believe that in any event chaos would result and everyone, excepting propagandists for a particular view, is of the opinion that the internal situation of Russia is such as to make the anxious diplomatist pause a long time before staking too much upon that country.

The general view of experts is that, having regard to all the diplomatic complications of collaboration with the Soviet and the great uncertainty of Russia's strength, the whole question should be considered with the greatest reserve. We must remember that Russia has no sentimental affection for Great Britain. Those competent to express a view are of the opinion that at the best Russia could not be regarded as a reliable ally.

The European situation, already bad enough, is complicated by persistent provocation in the Far East. That there is a distinct relationship between events in China and the policy of the Third Reich none can doubt; the center of danger lies in Berchtesgarden.

Although much more must be done, none the less British aircraft production is now probably the highest in the world. The quality of aircraft and pilots is unrivalled; a substantial land force is in process of creation; the navy is in excellent condition and construction proceeds apace, while the spirit of the Empire was never more fervent. The unqualified success of their Majesties' visit to Canada is a demonstration of this.

The tragedy is that the really vital interests of the Empire have become clouded by a vast Press campaign in London and Paris which, when combined with foreign propaganda directed against the Empire, has hampered the statecraft of both British and French Governments. Never in the history of diplomacy have the facts been so distorted by propagandists.

The difficulties with the Soviet are two-fold. First, there are certain important countries between the frontiers of the Third Reich and



Russia which are not prepared to enter into an alliance with the U.S.S.R. or be guaranteed by Great Britain. We must state quite bluntly that recent reports from Finland, Estonia and Latvia have been of a highly unsatisfactory nature. They indicate that these three countries, the friendship of which is of great importance to Britain, are being alienated and in one case at least there is a growing hostility which may have serious repercussions. The officialdom of these three countries was largely recruited from the ex-Tsarist bourgeoisie and has no love for the U.S.S.R.

The extreme dangers of alienating the Baltic States cannot be over emphasized. If pressure from certain quarters insists on a forced guarantee of these States, then they will move toward the German side, thus safeguarding for Germany the iron ore deposits of Sweden. The Reich will also gain undisputed control of the Baltic, a crucial point in Germany's favor in case of a prolonged war. Most people have no conception of the dangers toward which we are moving. Light hearted dismissal of these problems by certain sections of the Press is in direct opposition to the strongest recommendation of expert observers.

The second difficulty with Russia arises from the character of public opinion in that country and the nature of her military ability. A brilliant report from an observer who has been traveling in the U.S.S.R. with particular facilities stresses the fact that that country has kept certain characteristics of the old Russia, indeed those very characters which made her so different from the Western countries, the extreme slowness of the bureaucratic system, the disorder of the administration, the unbelievable nonchalance of the officials, their corruptibility and their desire to respect the general line of policy adopted by the powers that be. On the other hand, the tremendous national pride of the pre-war Russia has been revived in the Soviet citizen of today. The former believed that the orthodoxy of his Church in preserving Russia from the bad influence of the West placed the Empire of the Tsars at the head of Christendom and the latter is just as convinced of the redeeming powers of the Socialism of Lenin and Stalin. The mystical character of modern Russia, though it has a different character and objective, is none the less intense and it is not

only owing to propaganda that the average Soviet citizen is still convinced today of the fact that his own race is superior to those of the West.

The revolution, in breaking up the Baltic States and in exiling a number of families of European origin, crushed a large proportion of the Western influences in Russia. Whereas the Russia of the Tsars had its center of gravity somewhere between St. Petersburg and Moscow that of the U.S.S.R. is somewhere between Moscow and Tiflis.

The choice of Moscow as the capital of the Union was the first step towards the East and creation of the big centers of the Ural and Kuznetsk confirms the view that the Soviets in spreading towards the East were considering the organization of Asia as the essential part of the political destiny of the U.S.S.R.

The report continues to stress that it is not the intention of the Soviet Government to intervene in a European conflagration and that the public is being educated to think of Asiatic rather than European problems. Propaganda relating to foreign affairs deals more with the problems, for example, of Outer Mongolia, Chinese Turkestan and Persia than with European matters. The Russian workman on his way to the factory, if he discusses foreign policy at all, talks of Asiatic and not European problems. It would be as rare to hear a Russian workman talk about the issues of Western Europe as it would be to hear a British workman discuss the problems of Chinese Turkestan. The report is, of course, referring to Russia and not to Moscow. The average Englishman has a complete misconception as to the outlook of the Soviet citizen. Our report stresses the fact that the statesmen who were in favor of intervention in the West have been liquidated. The last of them was M. Litvinoff, who has recently been dismissed.



Physicians visiting the New York World's Fair are entitled to exclusive privileges in the Professional Club in the same building. Admission is obtained by simple identification as a doctor, without charge, and is only available to physicians and their guests. Provision is made here for consultation with exhibit sponsors on technical questions.

# Association of Connecticut Tumor Clinics

## A Symposium Presented at the Thirteenth Meeting of the Association Held at New Britain General Hospital, April 13, 1939

### SUMMARY OF EXPERIENCE WITH MALIGNANCIES AT NEW BRITAIN GENERAL HOSPITAL, 1929-1938\*

Paul D. Rosahn, M.D.  
New Britain, Conn.

In planning this program it was thought that a survey of all of the malignancies observed at the New Britain General Hospital during the decade 1929 to 1938 would be of considerable interest. Aside from giving us an opportunity to analyze and evaluate our experience with tumors in the past, such a review it was felt would also serve to establish a base line or control to be used for comparative purposes in the evaluation of our results in the future. It is realized that the material here to be presented is in many instances inadequate for statistical treatment, and therefore no attempt will be made to apply our conclusions to the general field of tumor work. What this report does purport to do however, is to describe the tumor experience at this hospital during the past decade.

A brief review of our tumor clinic activities is in order at this time. Up until 1937 the hospital had no facilities for radiation therapy and patients requiring this type of treatment were of necessity referred elsewhere. Early in 1937 provision was made for the installation of equipment considered adequate for radiation therapy in a hospital of this size and thereafter it was no longer necessary to refer our patients to other institutions for this type of treatment. However, the hospital has not been in a position to secure any radium and a great majority of patients requiring radium treatment had to obtain it

elsewhere. This lack of radium has continued up until the present, but recently efforts have been made to secure an adequate supply and it is hoped that enough radium to meet our needs will soon be available.

A systematic follow-up of our tumor patients has not been possible until January 1st of this year, when an out-patient tumor clinic was organized. Before this time any follow-up information that was obtained consisted of observations on patients returning to the hospital for radiation therapy. Our out-patient tumor clinic is now actively functioning as an integral part of the hospital organization. Adequate secretarial and social service assistance has been provided, and as a result it is hoped that a more thorough and systematic follow-up of our tumor patients will be obtained in the future.

Before proceeding to the main body of this report, a few explanatory statements should be made. One of these is concerned with the methods used in obtaining our follow-up information. We have had invaluable assistance from Dr. Griswold and Mr. Hirsche of the Division of Cancer Research of the State Department of Health. Without their aid the excellent follow-up result which we have obtained would not have been possible. In addition, we have had recourse to the Vital Statistics records of the City of New Britain, and to the office records of local physicians under whose care many of the patients had come. Our greatest difficulty was in securing follow-up information on out-of-town patients. For this purpose we communicated with the town clerks of the distant communities, and in every such instance we received excellent and prompt cooperation. The local and out-of-town

\*From the Tumor Clinic and Laboratory Division of the New Britain General Hospital, New Britain, Connecticut, and the Department of Pathology, Yale University School of Medicine, New Haven, Connecticut.



Visiting Nurse's Association rendered assistance as did also the local post office. All of these agencies have played an important part in helping us to secure follow-up information on 445 of our 447 cases.

The second explanatory statement is concerned with the methods employed in analyzing our data. We hold no brief for statisticians, but we do believe that the application of recognized statistical methods is of great importance in the evaluation and interpretation of results. For this reason, our findings have been submitted to statistical tests wherever possible. It is not necessary to describe the technique of these tests. It is important, however, to emphasize that in the following report an observation will be described as "significant" only if the odds against its chance occurrence are less than one in 100.

**TABLE I**  
**Summary of Malignancy Diagnoses**  
**at**  
**New Britain General Hospital**  
**1929-1938**

	Number	Percent
Cases discharged with diagnoses of malignancy or questionable malignancy but excluded from this report.....	72	13.9
Cases discharged with diagnoses of malignancy included in this report.....	447	86.1
Total.....	519	100.0

The material for this review was gathered by selecting from our hospital records all charts bearing a diagnosis of malignancy or questionable malignancy during the period of January 1, 1929 to December 31, 1938. These diagnoses include not only the carcinoma and sarcoma groups, but also leukemias and Hodgkin's disease. A total of 519 cases was reviewed (Table I). Seventy-two or 13.9% of these impressed the reviewer with a reasonable doubt as to the accuracy of the discharge diagnosis of malignancy and this group is not included in the survey. An analysis of the reasons for rejecting these cases is presented in the accompanying table (Table II). It will be seen that five cases were rejected because the diagnosis of malignancy was changed in the light of subsequent events. Two of these five cases, diagnosed carcinoma of the stomach

**TABLE II**

**Analysis of Cases at New Britain General Hospital**  
**1929-1938 Discharged with Diagnosis of Malignancy or Questionable Malignancy but Excluded from this Report**

	Number	Percent
Diagnosis changed in the light of subsequent events.....	5	6.9
Benign lesion histologically, but discharged with diagnosis of questionable malignancy.....	13	18.1
Patient in extremis on admission and adequate work-up not obtained	17	23.6
Clinical findings only, with reasonable doubt as to accuracy of diagnosis of malignancy.....	21	29.2
Diagnosis of malignancy based on equivocal x-ray findings.....	16	22.2
Total.....	72	100.0

by x-ray, were subsequently shown to be syphilitic and clinical improvement occurred following the administration of anti-leuitic treatment. Two others diagnosed as brain tumor subsequently recovered without operation and the last diagnosed as lymphoblastoma of the stomach, at subsequent operation proved to have no evidence of gastric pathology. Biopsies were obtained in thirteen of these rejected cases and a benign lesion was reported in all. In spite of this report, these patients were discharged with a diagnosis of malignancy. This difference between the discharge diagnosis and the pathological report probably was the result of the clinical impression that the biopsied material did not represent an adequate sample of the suspected lesion. A certain proportion of these cases, no doubt, did have a malignancy, but they were all excluded since there was no definite evidence upon which such a diagnosis could be based. Seventeen patients were admitted in extremis and died before any clinical investigation could be conducted. This group was also excluded in spite of the fact that the clinical diagnosis was probably justified in a certain proportion of these cases. A diagnosis of malignancy was based on clinical findings alone in 21 cases, and in all of these there existed a reasonable doubt in the mind of the reviewer as to the accuracy of this diagnosis. Here again, it is very probable that a certain proportion of these cases did have a malignant tumor, but they were all excluded for the reason stated. The last group of 16 patients included those with a diagnosis of

malignancy made on the basis of equivocal x-ray findings. The review to be presented, therefore, is based upon the remaining group of 447 malignancies seen in this hospital in the past decade. The evidence upon which the diagnosis was made in these cases will be presented in the body of this report.

TABLE III  
Distribution by Sex of 447 Malignancy  
Cases at New Britain General  
Hospital 1929-1938

Sex	1929-1933		1934-1938		1929-1938	
	No.	%	No.	%	No.	%
Male.....	75	47.8	133	45.9	208	46.5
Female.....	82	52.2	157	54.1	239	53.5
Total.....	157	100.0	290	100.0	447	100.0

In the third table is presented an analysis of the 447 cases by sex. It will be seen that 46.5% occurred in males and 53.5% in females. The difference between these values is significant. Splitting these cases into two 5 year periods gives approximately the same sex distribution, i.e., 47.8% males and 52.2% females in the period 1929-1933, inclusive, and 45.9% males and 54.1% females in the period of 1934-1938, inclusive.

TABLE IV  
Comparison of Sex Distribution of  
Malignancy Cases in Three  
Communities\*

Sex	Community and Year of Survey		
	Willimantic 1928-1938	New Haven 1925-1934	New Britain 1929-1938
	Percent	Percent	Percent
Male.....	39.6	43	46.5
Female.....	60.4	57	53.5
Total Percent.	100.0	100	100.0
Total number.	303	3074	447

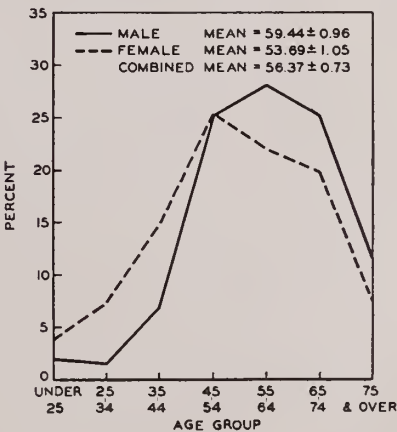
\*Willimantic — Windham Community Memorial Hospital 1928-1938  
New Haven — Grace, St. Raphael's, New Haven Hospital 1925-1934  
New Britain — New Britain General Hospital 1929-1938

The difference frequency of malignancies in the two sexes noted at the New Britain General Hospital is paralleled by the findings in other communities. In Table IV is presented a comparative analysis of the sex of the malignancy cases in Willimantic, New Haven and New Britain. The data for Willimantic was obtained

from Ottenheimer's report in the March issue of the Journal of the Connecticut State Medical Society. The data for New Haven was obtained from Hirsche's report entitled "Cancer in New Haven" which is based on cases occurring at the Grace, St. Raphael, and New Haven Hospitals. It will be seen from this table that the frequency of malignancies in males ranges from a low of 39.6% in Willimantic to a high of 46.5% in New Britain with an intermediate position of 43% in New Haven. A statistical analysis of these figures reveals no significant difference among the three communities with respect to the sex distribution of malignancies. The variation noted above can be accounted for by the element of pure chance alone. However, in each community significantly fewer males had cancer than females. On the basis of these summated findings it can be said that cancer is less frequently observed in the male and more frequently in the female.

TEXT FIGURE I

AGE DISTRIBUTION OF MALIGNANCY CASES  
NEW BRITAIN GENERAL HOSPITAL 1929-1938



The first chart (Text fig. I) gives a pictorial representation of the age of the malignancy cases at the New Britain General Hospital. The modal class, i.e., the age group with the greatest number of cases, was 45-54 years for females and 55-64 years for males. Cancer occurred more frequently in females under 45 than in males, and more frequently in males over 54 than in females. The mean age of males in the entire group was 59.4±1.0 years, and of females 53.7±1.1. The difference between these two



values is highly significant statistically. In the next table (V) is shown the mean age of males and females in the two 5 year periods included in this report. The mean age of males was higher than that for females in each five year period and in each instance the observed difference is significant statistically. Moreover, there was no significant difference between the mean age of males or of females in the first five year period as compared to the corresponding value in the second five year period. It can be said then, on the basis of this analysis, that the age of malignancy was significantly higher in males than in females and that no significant alteration of this relationship occurred in either of the five year periods studied.

TABLE V  
A Study of 447 Malignancies at  
New Britain General Hospital  
1929-1938  
Mean Age of Male and Female Groups

Year	Sex			
	Male		Female	
	No.	Mean Age in Years	No.	Mean Age in Years
1929-1933.....	75	59.1 $\pm$ 1.5	82	52.4 $\pm$ 1.9
1934-1938.....	133	59.5 $\pm$ 1.2	157	54.1 $\pm$ 1.4
1929-1938.....	208	59.4 $\pm$ 1.0	239	53.7 $\pm$ 1.1

The next table (VI) presents an analysis of the anatomical distribution of these 447 cases. The greatest number, or 14.5% of the total, had their primary site in the intestine, and the smallest number, or 5.4% of the total, in the skin. Between these two values range the other organs: breast, female genitalia, stomach and urogenital system. An analysis of these figures fails to reveal any significant difference at this hospital in the proportion of tumors of the intestine, breast, female genitalia, stomach or urogenital system to all malignancies. Moreover, a breakdown by five year periods fails to alter the distribution noted over the entire decade. In no case was there any significant difference between the proportion of tumors of any system in the first five year period as compared to the value for the same system in the second. In summary, it can be said that the proportion of tumors occupying each of five major sites was constant in each of the two 5 year periods.

It is of interest in considering the topographical distribution of malignant tumors to compare

TABLE VI  
Anatomical Distribution of  
447 Malignant Tumors  
New Britain General Hospital, 1929-1938

Site	Period					
	1929-1933		1934-1938		1929-1938	
	No.	%	No.	%	No.	%
Intestine.....	19	12.1	46	15.9	65	14.5
Breast.....	19	12.1	40	13.8	59	13.2
Female Genital.....	16	10.2	40	13.8	56	12.5
Stomach.....	22	14.0	33	11.4	55	12.3
Urogenital*.....	23	14.7	32	11.0	55	12.3
Skin.....	5	3.2	19	6.6	24	5.4
All Others.....	53	33.7	80	27.6	133	29.8
Total.....	157	100.0	290	100.1	447	100.0

\*Excluding Female Genital

our findings with those at other institutions. Tables VII and VIII present such a comparison. The data for Windham Community Memorial Hospital was obtained from Ottenheimer's report previously referred to, and that for Hartford Hospital was secured from McLellan's discussion of this paper. A statistical analysis of these findings (Table VII) reveals that there is a highly significant difference among the institutions represented with respect to the topographical distribution of malignant tumors. This difference is accounted for by variations in the number of tumors occurring at four sites. The New Britain General Hospital had a significantly lower proportion of tumors of the female genitalia than did either of the two other hospitals. The Windham Community Memorial Hospital had a significantly lower proportion of tumors of the urogenital system, a significantly higher proportion of tumors of the skin, and a significantly lower proportion of tumors involving "other organs" than was observed at either of the other two hospitals. With respect to tumors of the intestine, stomach and breast, the three institutions had a similar proportion of tumors. The high number of tumors of the skin noted at Willimantic suggests the tentative conclusion that skin tumors occur more frequently in rural than in urban communities. No immediate reason can be given for the low proportion of tumors of the urogenital system in Willimantic or for the low proportion of tumors of the female genitalia in New Britain.

A similar comparison of the topographical distribution of malignant tumors observed at the New Britain General Hospital with the

TABLE VII  
Comparison of Anatomical Distribution of Malignant Tumors at Windham Community Memorial, Hartford, and New Britain General Hospitals

Site	Hospital and Year of Survey		
	W.C.M.H. 1928-1938	H.H. 1932-1936	N.B.G.H. 1929-1938
	Percent	Percent	Percent
Intestine.....	12.9	12.4	14.5
Breast.....	18.2	14.9	13.2
Female Genital	17.8	18.0	12.5
Stomach.....	11.2	9.3	12.3
Urogenital*..	5.6	10.1	12.3
Skin.....	15.5	6.7	5.4
All Others....	18.8	28.6	29.8
Total Percent..	100.0	100.0	100.0
Total Number	303	2015	447

\*Excluding female genital

TABLE VIII  
Comparison of Anatomical Distribution of Malignant Tumors at New Haven Hospitals and New Britain General Hospital

Site	Hospital and Year of Survey	
	Three New Haven Hospitals 1925-1934	New Britain General Hospital 1929-1938
	Percent	Percent
Stomach and Liver.....	17.2	16.8
Peritoneum, Intestines and Rectum	15.4	14.5
Female Genital....	15.8	12.5
Breast.....	19.0	13.2
Skin.....	5.3	5.4
All Others....	27.2	37.6
Total Percent..	99.9	100.0
Total Number	3074	447

findings reported by Hirsche in three New Haven Hospitals is shown in Table VIII. It was necessary to segregate the New Haven Hospital's group from the other hospitals in making this comparison because of the fact that the topographical distribution followed by Hirsche is based upon a different classification, that of the "International List of Causes of Deaths." Our own findings were reassembled in order to conform with Hirsche's classification in preparing this chart. A highly significant difference between the two series is observed. This significant difference is accounted for by different proportions of malignant tumors at two sites. The New Haven hospitals had a higher proportion

or breast tumors than was observed at New Britain and this difference is significant statistically. The New Britain General Hospital had a higher porportion of "all other" tumors than was observed in the New Haven hospitals and again this difference is statistically significant. With respect to tumors involving the stomach and liver, the peritoneum, intestine and rectum, the female genitalia, and the skin, our findings showed no significant difference from those reported by Hirsche for the New Haven hospitals. The higher proportion of breast tumors in New Haven can probably be accounted for by the great number of cases referred to the teaching center in that community. In summary then, it is found that the proportion of tumors of the intestine and stomach for the four communities herein discussed showed no difference. The New Britain Hospital had a lower proportion of tumors of the female genitalia than was observed at both the Windham Community Memorial Hospital and the Hartford Hospital, but a similar proportion to that observed at the New Haven hospitals. The New Britain Hospital had a similar proportion of tumors of the breast as that observed in Willimantic and Hartford, but significantly lower than that observed in New Haven. Willimantic had a significantly lower proportion of malignancies of the urogenital system than was observed either at Hartford Hospital or New Britain Hospital and a significantly higher proportion of tumors of the skin than was seen at any of the three other communities.

Up to this point our discussion has been concerned principally with the age and sex of the patients with malignant tumors, and with the topographical distribution of these tumors. At this point a discussion of the evidence upon which the diagnosis of malignancy was based is in order. For this purpose, the criteria for the grading of diagnoses which were elaborated by the Committee of Pathologists of this Association have been followed. A "grade A" diagnosis in this system is a diagnosis which is based upon histological findings. This in a sense is a "positive" diagnosis. A "grade B" diagnosis is one which is based upon x-ray findings, or findings at operation. This grade represents a "probable" diagnosis. The last group termed "grade C" is one based upon clinical findings only. This is a "possible" diagnosis. Our table IX shows a



grouping of the malignancy cases included in this report according to anatomical site and grading of the diagnostic evidence. It will be seen that the highest proportion of "grade A" diagnoses, i.e., diagnoses based upon histological findings, were in tumors of the breast. Ninety-five per cent of these malignant tumors were diagnosed by histological study. At the same time, "grade A" diagnoses of tumors of the stomach were the most infrequent, only 27% of such malignancies having been diagnosed on the basis of histological examination. It is also of interest to observe that malignancies of the stomach had the highest proportion of "grade B" diagnoses. More than  $\frac{2}{3}$  of all of the tumors of the stomach were diagnosed by x-ray or at operation. In summary, it will be seen that 62% of all of the tumors discussed in this report were diagnosed by histological study, and an additional 26% were diagnosed by x-ray or at operation. Only 11.6% of the entire group were diagnosed by clinical findings alone.

TABLE IX

A Study of 447 Malignancies at  
New Britain General Hospital, 1929-1938

## Grading of Diagnostic Evidence

Site	Grades of Diagnoses			Total Number
	A %	B %	C %	
Breast.....	94.9	0	5.1	59
Female Genital...	83.9	3.5	12.5	56
Urogenital*.....	54.5	20.0	25.5	55
Intestine.....	44.6	47.7	7.7	65
Stomach.....	27.3	67.3	5.5	55
All Others.....	63.7	21.7	14.6	157
Total.....	62.0	26.4	11.6	447

\*Excluding Female Genital

A — Diagnosis based on histological findings

B — Diagnosis based on x-ray or operative findings

C — Diagnosis based on clinical findings

So much for a consideration of the diagnostic evidence without relation to time. The question arises whether or not there has been any change in the type of diagnostic evidence in the second five year period as compared with the first. Such an analysis is presented in table X. It is seen from this table that 57% of the malignancies observed in the first five year period were based upon "grade A" evidence. A slightly higher proportion of diagnoses, i.e., 64.5% of the tumors

in the second five year period, were based upon similar evidence. This difference when analyzed statistically is well within the limits of chance deviation. "Grade B" diagnoses occurred in 26% of all cases observed in both the first and the second five year periods. "Grade C" diagnoses fell from 16% in the first five years to 9% in the second five years. Here again, the difference is not significant statistically. It can be said, however, that there appears to be an increased proportion of "grade A" diagnoses and a decreased proportion of "grade C" diagnoses in the period 1934 to 1938 as compared to the period 1929-1933. We shall return to the discussion of grading of diagnoses in a subsequent paragraph.

TABLE X

A Study of 447 Malignancies at  
New Britain General Hospital, 1929-1938

## Grading of Diagnostic Evidence

Year	Grades of Diagnoses						Total	
	A		B		C			
	No.	%	No.	%	No.	%		
1929-1933	90	57.3	42	26.8	25	15.9	157	100.0
1934-1938	187	64.5	76	26.2	27	9.3	290	100.0
1929-1938	277	62.0	118	26.4	52	11.6	447	100.0

A — Diagnosis based on histological findings

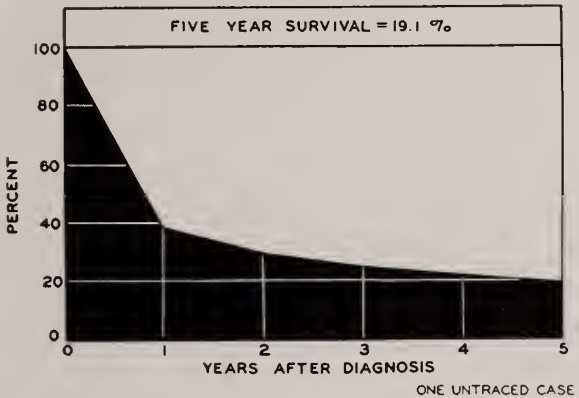
B — Diagnosis based on x-ray or operative findings

C — Diagnosis based on clinical findings

In any discussion of malignancies, an analysis of the survival rate is of extreme value. A summary of the survival rate one to five years following the diagnosis is shown in the next chart (Text fig. II.) We have followed the method of Hirsche in preparing this graph. Only those cases were included which were seen in the hospital five or more years ago, i.e., only those on which a possible five year survival could be traced. 157 cases occurred in the first five year period of this survey. A follow-up was obtained in every one of these cases with only one exception. Before the end of the first year, 62% of these patients had succumbed, and an additional 19% died before the end of the fifth year. Thirty patients or 19.1% of the total survived for five or more years following the original diagnosis. This compares with a value of 19.4% obtained by Hirsche in a similar analysis and a value of 24% observed by Ottenheimer. It should be emphasized that the Ottenheimer survival rate

does not include skin tumors. In our experience approximately 40 per cent of malignancy cases survived the first year, and 20 per cent the fifth year. Thus an individual living one year after the diagnosis had a one in two chance of surviving five or more years.

TEXT FIGURE II  
SURVEY OF MALIGNANCIES  
SURVIVAL RATE ONE TO FIVE YEARS  
FOLLOWING DIAGNOSIS  
NEW BRITAIN GENERAL HOSPITAL 1929-1933  
TOTAL = 157 CASES



The next table (Table XI) presents an analysis of the 30 cases surviving five or more years. It shows the anatomical site of these malignancies and analyzes the evidence upon which the diagnosis of malignancy was based. Nine out of the 30 cases had tumors of the breast and all nine of these cases were diagnosed malignant by histological section. Two-thirds of this group were diagnosed by histology and 90% were diagnosed

TABLE XI  
Analysis of 157 Malignancies\* at  
New Britain General Hospital, 1929-1933

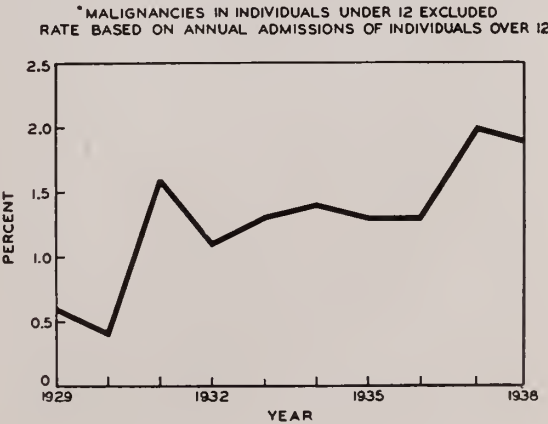
Site	Grades of Diagnoses		
	A	B	C
Breast.....	9	—	—
Female Genital.....	3	—	—
Intestine.....	1	1	1
Urogenital.....	1	—	—
Stomach.....	—	2	—
All Others.....	6	4	2
Total.....	20	7	3
Percent.....	66.7	23.3	10.0

\*One untraced case

either by histology or by x-ray, leaving only 10% of the entire group or three individuals whose diagnoses were based on clinical findings alone.

In the next chart (Text fig. III) is presented a breakdown of the malignancies upon which this report is based by year of diagnosis. In preparing this table, seven malignancies in individuals under 12 were excluded. These consisted of three cases of leukemia, two lymphosarcomas, one sarcoma of unknown origin, and one malignant thymoma. The rate was based upon the hospital admissions of individuals over 12 years of age during each year of the period under consideration. In 1929 and 1930 malignancies were found in about one-half of one per cent of admissions of individuals over 12 years of age. There was a slight rise in 1931 to 1.6%, followed by a fall in 1932, and a fairly level plateau with a rate between 1.1 and 1.4% from 1932-1936. There was then a rise to a level of 2% in 1937 which was maintained in 1938. Indications at present based upon our experience in the first three months of 1939 are that the rate will probably rise to around 2.5% in the current year. The fall in incidence in 1930 and the rise again in 1931 have their probable explanation on the basis of the depression. Patients requiring hospitalization remained away from the hospital in 1930 until the situation became so bad that they were forced to come to the hospital in 1931. It should be emphasized that the malignancy rate in the period 1937 to 1938 is statistically significantly higher than in 1935-

TEXT FIGURE III  
INCIDENCE\* OF MALIGNANCIES  
NEW BRITAIN GENERAL HOSPITAL 1929-1938





1936. There would have been no change in the trend of this curve had the 72 cases originally excluded from this report been included in the computation of yearly incidence rates.

The fact of this increase in the incidence of malignant tumors in the later years of this survey is evident from the graph. The explanation for this increase, if one can be found, should prove to be of considerable interest. Either one or the other or both of two hypotheses are suggested. The first hypothesis postulates that the increased incidence is due to a greater proportion of individuals in the later age groups as a result of increasing longevity in the general population. The second suggests that the increase is a result of greater accuracy of diagnosis and earlier recognition of symptoms, with resulting earlier hospitalization than was the case in former years.

The first of these hypotheses has been tested, using the hospital admissions as the test group. In the period under consideration, 1929-1938, 440 malignancies were noted in individuals over 12 years of age. A sampling of the hospital admissions of individuals over 12 years of age during the same period was obtained, and on the basis of this sampling, the total number of admissions of each sex in each age decade was calculated for the ten year period. The morbidity rate standardized for age and sex was then determined by relating the age and sex groups of the malignancy cases to the age and sex groups of the calculated number of admissions. Using these standardized rates, the expected number of cancer cases was calculated for the years 1929 and 1938. This expectancy was based upon the admissions to the hospital during each of these two years. The table (Table XII) shows the resultant figures. Only nineteen cases were actually observed in 1929, while the expected rate was more than double this number, or 43 cases. On the other hand the 75 cases observed in 1938 represented a greater number than the expected value of 51 cases. The increase in the expected number from 43 cases in 1929 to 51 cases in 1938 is the increase which is directly the result of an increasing proportion of patients in the older age groups. However, the difference between the expected number of cancer cases in 1938, 51, and the observed number, 75, cannot be accounted for only on the basis of increasing numbers of individuals in the later age groups. Other factors were responsible for this difference

between the observed and expected values in 1938, and it is believed that these were first, earlier diagnosis, and second, more accurate diagnosis.

TABLE XII  
Observed and Expected Number of Malignancies  
at  
New Britain General Hospital  
in 1929 and 1938

	1929	1938
Observed number of cancer cases....	19	75
Expected number of cancer cases*...	43	51

\*Based on 440 malignancies in individuals over 12 and on hospital admissions of individuals over 12 from 1929 to 1938, with rates standardized for age and sex.

To test this hypothesis, the following analysis was made. Table XIII shows the number of deaths within one year following the diagnosis for all cases observed in 1929 as compared to those observed in 1937, the last year of this survey for which a one year follow-up is available. Fifteen out of nineteen cases seen in 1929, or 79.9% were dead before the end of the first year. This compares with the value of 42 out of 80 cases diagnosed in 1937, or 52.5% dead within one year following diagnosis in that year. The difference between the one year death rate in 1929 and the one year death rate in 1937 is statistically significant. Since no intestinal cases were seen in 1929, and fourteen occurred in 1937, the intestinal group was excluded in order to make the comparison more equitable. The resultant figures are 79.9% one year deaths in 1929

TABLE XIII  
Analysis of Malignancies at  
New Britain General Hospital in 1929 and 1937

Site	Deaths within One Year Following Diagnosis					
	Year of Diagnosis					
	1929		%	1937		%
	1 Yr.	Total		1 Yr.	Total	
	Deaths	Cases		Deaths	Cases	
Stomach.....	3	3	100.0	11	12	91.7
Intestine.....	0	0	—	10	14	71.4
Urogenital....	4	4	100.0	4	13	30.8
Female Genital	1	4	25.0	2	8	25.0
Breast.....	1	2	50.0	3	13	23.1
All Others....	6	6	100.0	12	20	60.0
Total.....	15	19	79.9	42	80	52.5
Total excluding intestine....	15	19	79.9	32	66	48.5
All cases traced						

as compared with the significantly lower value of 48.5% one year deaths in 1937. All of these cases were traced. If we concede that one year deaths represent those cases seen too late for surgical intervention and those which though operable are too far advanced for procedures aimed at eradicating the tumor, then it is evident that in this hospital we have seen more cases in the earlier stages of their disease in 1937 than we did in 1929.

In addition to earlier diagnosis, there is also evidence of more accurate diagnosis in the later years as compared to the earlier years. This is seen in table XIV which shows a grading of the diagnostic evidence, similar to that discussed previously, in the earlier years 1929 and 1930 as compared to the later years 1937 and 1938. In this table diagnostic evidence indicating grades "A" and "B" have been grouped together. 78.8% of the cases seen in 1929 and 1930 had "grade A" or "grade B" diagnoses. This compares with a significantly higher value of 91.5% "grade A" or "B" diagnoses in the cases seen in 1937 and 1938. The reverse of this picture is perhaps more striking. 21% of the cases seen in the first two years of this survey had a "grade C" diagnosis, while the significantly lower value of 8.5% "grade C" diagnoses occurred in the last two years of this survey. The evidence therefore appears to point to the fact that we are seeing tumor cases earlier and we are making more accurate diagnoses. Both of these factors have probably contributed to the increased incidence of tumor admissions which we have noted.

TABLE XIV  
Grading of Evidence for  
Diagnosis of Malignant  
Tumors at New Britain General Hospital

Grade	Year					
	1929-1930		1937-1938		Total	
	No.	%	No.	%	No.	%
A and B.....	26	78.8	146	94.2	172	91.5
C.....	7	21.2	9	5.8	16	8.5
Total.....	33	100.0	155	100.0	188	100.0

- A — Diagnosis based on histological findings
- B — Diagnosis based on x-ray or operative findings
- C — Diagnosis based on clinical findings

In considering this very forward step in tumor work in this community due credit should be given to the educational activities of the Division of Cancer Research of the State Department of Health and to the Association of Connecticut State Tumor Clinics. Mention should also be made of the fact that radio-therapy equipment was installed at this hospital in 1937, the year when a marked increase in tumor cases was first noted.

Before closing this discussion, one other matter deserves attention. On the basis of our experience in this institution, which is the only hospital in the community, is it possible to predict the cancer morbidity rate in the area served by it? An attempt at such an estimation was made and is presented in table XV. The methods used in the analysis are at this moment of no great importance. Suffice it to say that morbidity rates standardized for age and sex based upon cases seen in this hospital in the ten year period of this survey (64 out-of-town cases were excluded), and the estimated number of individuals in each age and sex group admitted to this hospital during the same period (based upon a sampling considered statistically adequate), were calculated. These rates were then applied to the age and sex groups of the New Britain population as revealed by the census of 1930. The resulting figures show the estimated number of malignancies in the community: 268 male cases and 321 female cases, or a total of 589 cases. This estimate is offered very tentatively. An alternate method of estimating morbidity rates is now being developed and will be used as a check on this estimate. A future report will present the method involved in greater detail. It should be said, however, that our estimated total cancer morbidity is from seven to eight times the reported cancer mortality rate in this community. The usual estimate, although no very detailed reports are available to indicate the basis for this conclusion, is that cancer morbidity is three times cancer mortality. Our own figure indicates that cancer morbidity represents seven to eight times cancer mortality. If this estimate proves to be correct, the magnitude of the task confronting those interested in tumor work is far greater than any of us ever realized.



### Summary

1. Four hundred and forty-seven malignancies were observed at the New Britain General Hospital during the decade of January 1, 1929 to December 31, 1938.
2. Of these, 62 per cent were diagnosed by histological findings and 11.6 per cent by clinical findings alone.
3. Fifty-three and five tenths per cent occurred in females and 46.5 per cent in males.
4. The mean age for females was  $53.7 \pm 1.1$  years, and for males  $59.4 \pm 1.0$  years. The difference between these two values was significant.
5. The largest proportion of these malignancies had their primary site in the intestine; breast and female genitalia were the second and third organs most frequently involved. However the differences noted were not statistically significant.
6. A follow-up to December 31, 1938 was obtained on 445 of the 447 patients.
7. Nineteen per cent of 157 patients observed during 1929 to 1933 were alive five or more years following the diagnosis. The diagnosis was based on histological findings in two-thirds of these five year cures.
8. There was a progressive increase in the incidence of malignancies from 1929 to 1938.
9. Accompanying this increase there was evidence of earlier and more accurate diagnosis.
10. It was estimated that the City of New Britain has a cancer morbidity at any given time of over 500 cases.

TABLE XV  
Estimate of Malignancy Cases in New Britain  
based on  
Cancer Rate at New Britain General Hospital 1929-1938

Age	Hospital Admissions* 1929-1938		Malignancies** at N.B.G.H. 1929-1938		Malignancies** per 1000 Admissions 1929-1938		Population of New Britain 1930 Census		Estimated Number of Malignancies in New Britain		
			Male	Female	Male	Female			Male	Female	Total
13-14.....	604	344	—	—	—	—	—	—	—	—	—
15-24.....	2685	6663	1	4	0.4	0.6	5974	6467	2	4	6
25-34.....	1797	7511	2	14	1.1	1.9	5068	5376	5	10	15
35-44.....	2261	3633	14	30	6.2	8.3	5581	5027	35	42	77
45-54.....	1917	1797	44	52	23.0	28.9	3639	3090	84	89	173
55-64.....	1252	1089	45	40	35.9	36.7	2083	1975	75	73	148
65-74.....	848	524	41	42	49.5	80.2	947	1007	47	81	128
75 and over.....	264	200	21	13	79.5	65.0	248	344	20	22	42
Total.....	11628	21761	168	195			23540	23286	268	321	589

\*Estimate based on sampling of every tenth admission of individuals over 12 years in 1929, 1931, 1934, 1936, 1938.

\*\*Sixty-four out of town cancer cases excluded.

### A SURVEY OF GASTRO-INTESTINAL MALIGNANCIES DURING PERIOD FROM 1929-1938

George W. Dunn, M.D., New Britain, Conn.

This gastro-intestinal series includes fifty-five cases of gastric carcinoma and sixty-five cases of malignancies of the large and small bowel.

#### Carcinoma of stomach:

*Sex:* Forty males and sixteen females or 2.2 males to one female.

*History of the lapsed time from onset of any symptoms before admission to hospital.* Aver-

age 8.2 months — shortest two weeks and the longest two years.

#### Analysis of the most common symptoms:

*Pain:* Forty-one cases — 70%.

*Vomiting:* Thirty-three cases — 60%.

*Anorexia:* Forty cases — 70%.

*Weight Loss:* Forty-two cases — 71%.

*Change in bowel habit:* Forty cases — 70%.

The average age of patients was 57.4 years — the youngest was 28 years and the oldest was 80 years.

Out of these 56 cases 5 refused operation, 13 were considered too poor surgical risk, 16 were

found inoperable on exploration and in 22 cases either resection or gastro-enterostomy was done.

At the end of 10 year period 51 cases were dead and 5 living. Of the 5 living 1 is 7 years, one 6 years, one 2 years, one 1½ years and one 1 year. One case not included in this report lived 10 years after pathological diagnosis of carcinoma was made. The average duration of life was 9.6 months. This does not include deaths which were directly attributal to operation or immediate post operative complications. Four deaths.

Malignancies of Stomach

Age of Patients at Time of Diagnosis—  
55 Case

Age	Male	Female	Total
25-34		1	1
35-44	2	4	6
45-54	12	3	15
55-64	7	6	13
65-74	13	3	16
75 and over	2	2	4
	36	19	55

The conclusions to be drawn are comparable to those usually reported. The picture is not particularly edifying. It is obvious that the elapsed time before admission to hospital was entirely too long. It is significant that in only three cases of those operated were no evidences of any metastasis found. In other words, only about 6% of all cases held out any good hope of cure.

Malignancies of the Bowel were as follows —  
65 Cases

- Rectum — 17 cases
- Sigmoid — 22 cases
- Recto-sigmoid — 5 cases
- Descending Colon — 4 cases
- Cecum — 3 cases
- Ileo-Cecum — 1 case
- Transverse Colon — 7 cases
- Ascending Colon — 3 cases
- Ileum — 1 case
- Hepatic Flexure — 1 case

Of these cases 64 were diagnosed carcinoma and one sarcoma.

Age of Patients at Time of Diagnosis —  
65 Cases

Age	Male	Female	Total
25-34		1	1
35-44	4	2	6
45-54	9	5	14
55-64	11	10	21
65-74	7	9	16
75 and over	5	2	7
	36	29	65

The Follow-Up of Cases Living December 31,  
1938 was as follows:

There are 13 cases living. One — 8 years — carcinoma of sigmoid. One — 7 years — carcinoma of rectum. One — 6 years — carcinoma of sigmoid. One — 5 years — carcinoma of rectum. One — 3 years — carcinoma of cecum. Four — 2 years — one a sigmoid — one cecum and ascending colon — one transverse colon and one rectum. Four — one year — one a rectum and three sigmoid. Therefore only 20% of total cases were living at the end of ten year survey.

Number of Cases to Operation — 45

20 cases either refused operation or operation was considered inadvisable. 44% of these 65 intestinal cases were diagnosed by surgical specimen. In remaining cases palliative surgery is one of the ostomies. Again, as is usually reported, results are considerably more satisfactory in the case of intestinal malignancy. But the picture is rather dark and again delay in diagnosis stands out, since a great majority of these cases came into the hospital with marked obstructive symptoms. In considering what we might be able to do to obviate some of the difficulties it seems to me that we should consider the most common causes of delay.

*Fear* is unquestionably a considerable factor.

*Procrastination* enters in — as the patient is too often willing to procrastinate in hope of avoiding the issue.

*Most important is the matter of cost in time and money* in securing the diagnostic aids which the physician as well as the patient needs, as x-ray, biopsies, gastroscopy, etc. In view of the wide prevalence of gastric and intestinal disturbances, the physician is too likely to employ the usual palliative measures in the form of some type of medicine until patient's symptoms become such,



that he suspects some serious pathology. Too many times when the physician suggests some rather expensive procedure he perhaps loses his patient who goes through the same routine of treatment with some other physician, losing still more valuable time.

Since surgical procedures are quite standardized my thought is that if all our various means of diagnosis are made available to the man on the street at a price he can afford to pay we would be able to make earlier diagnosis, which is the first thing necessary in clearing up this dark picture.

## A STUDY OF MALIGNANCY OF THE BREAST — 1929-1938

William F. Flanagan, M.D.  
New Britain, Conn.

After one has heard the end results of a period of 10 years treatment of malignancy of the gastrointestinal tract with its obscure complaints, the inaccessible type of disease and the natural tendency of the patient to present himself in a belated stage of his indigestion, and then to analyze the statistics of breast cancer in the same period, one would expect a marked difference in end results. This is true but certainly far from what they ought to be, in such an accessible type of disease. In almost every case the difference between a cure and a failure was due to the time element prior to treatment.

During the 10 year period 1929-1938 a study of 59 cases of cancer of the breast was made. 56 of these were diagnosed by histological section. There were two males in this group and of the 57 females, 49 were married and of these 42 had one or more children.

The average age was 53.4 years and ranged from 25 to 82 years. There were no cases under 25 years:

- 4 cases from 25 to 34 years of age
- 9 cases from 35 to 44 years of age
- 18 cases from 45 to 54 years of age
- 11 cases from 55 to 64 years of age
- 12 cases from 65 to 74 years of age
- 5 cases from 75 and over

The most common symptom or complaint that caused the patient to consult her doctor was the presence of a mass in the breast, generally painless in character. One proven cancer,

its presence unknown to the patient, was found in a routine physical examination.

The presence of a mass was noted in 53 cases, pain in 15 cases, presence of a mole in one case, ulcer in four, discharging nipple in one and a loss of weight in three cases.

The location of the tumor was noted to involve the right breast in 28 cases, the left breast in 29 cases and both breasts in 2 cases. In the latter two cases it is interesting to note that each of these cases were operated on, one breast for a proven cancer and survived a period of 5 years before the second breast became involved. At the time of the second operation one case showed a localized tumor without metastases and this patient is alive, and well. The second case showed a mass the size of an orange with axillary metastases and died 5 years later as a result of cancer that occurred in the second breast. There was no evidence of recurrence on the site of primary operation. It seems hard to explain why this patient presented herself so late. In this group of 59 cases, 16 or 27.2% tumors were localized to the breast and 43 or 72.8% showed metastases.

The average delay occurring between the time that the patient first noted the complaint and ultimate hospitalization was 46½ weeks or approximately 11½ months. The time element of the duration of the disease prior to hospitalization was classified as follows:

- 3 cases less than one week
- 10 cases less than one month
- 13 cases under three months
- 3 cases 3-6 months
- 4 cases 6-9 months
- 1 case 12 months
- 7 cases 1-2 years
- 2 cases 2-3 years
- 2 cases 3-4 years
- 1 case 4-5 years
- 1 case 9 years
- 12 cases of unknown duration

The treatment rendered these patients was surgery with or without postoperative x-ray in all but one case where the patient was too poor a risk and the cancer too far advanced to warrant any surgical procedure. A radical operation was done on 53 cases or 89.8% of the group and a simple removal of the breast or tumor mass in 5 cases. 25 radicals were done without biopsy

previous to operation. 28 radicals were done subsequent to biopsy study. 19 patients received postoperative x-ray treatment. 5 cases admitted because of recurrence and 2 of these cases received palliative x-ray therapy. There was no operative mortality in this group. The end results are listed as follows:

- 7 died under one year
- 12 died 1-5 years after operation
- 1 died 5-6 years after operation
- 1 died 6-7 years after operation
- 1 died 7-8 years after operation
- 1 died 8-9 years after operation
- 1 died 9-10 years after operation
- 3 died from other causes

Those living are:

- 2 for one year or more
- 24 for one to five years
- 1 for six to seven years
- 3 for 7-8 years
- 1 for 8-9 years
- 1 for 10 years or more

The above figures present 100% follow-up.

Conclusion: In reviewing this group of breast cancers one learns again that the duration of the disease and its extent prior to proper treatment and the degree of malignancy are the deciding factors in such a high mortality in a type of tumor whose presence should be easily determined. There was willful neglect shown on the part of the patient in a great many of our cases in delaying to seek medical advice but unfortunately in a few cases our own confreres failed to give proper advice when consulted. Certainly an average waiting time of 11½ months is too long to expect even fair results of any surgeon or roentgenologist.

The plan of treatment for cancer of the breast at the New Britain Hospital at this time is a radical mastectomy including removal of the pectoral muscles, a thorough dissection of the axilla and the removal of other glands within reach. We have not used preoperative x-ray in many cases but have used post-operative radiation in many of our cases and it is becoming the routine treatment of cases with metastasis.

A frozen section is made in all cases except those that are so advanced that there is no possibility of a wrong diagnosis. This routine, especially in cases of a solitary mass has saved the patient an extensive operation in many cases and the surgeon a position of embarrassment.

For the hopeless far advanced cases simple removal of breast if indicated and deep x-ray as palliative treatment.

Post-operative irradiation for sterilization is advocated in all cases developing carcinoma of the breast prior to the menopause.

We are in accord with all, that a lump in the breast should be excised and considered cancerous until proven otherwise. It was noticeable in reviewing the pathological reports of these cases the high incidence of malignancy occurring in breasts that showed chronic mastitis.

It seems reasonable to assume that the responsibility to improve the statistics in breast cancer rests with the patient and the doctor in the field.

### MALIGNANCIES OF THE FEMALE GENERATIVE TRACT NEW BRITAIN GENERAL HOSPITAL 1929-38

Donald A. Bristoll, M.D., New Britain, Conn.

In the period from 1929 to 1939 according to the records there have been 56 cases of malignancy of the female generative organs admitted to the New Britain General Hospital. In the period of this follow-up, from 1929 to 1933 inclusive, there are only a total of 16 cases. These are subdivided into two cases of carcinoma of the vulva, 7 of carcinoma of the cervix, 3 of carcinoma of the ovary and 4 of carcinoma of the fundus. It is quite apparent that an attempt to draw any definite conclusions from such a series of cases is impossible, and I will make no attempt to do so.

It is of some interest, however, to see what happens to such patients in a general hospital where there has been no uniformity of treatment, and where, at the time mentioned, the most approved therapeutic armamentarium was lacking.

The cases of carcinoma of the vulva, average in the age of the patient 62½ years. The average time elapsing between symptoms and hospitalization was 7 weeks. One patient had no operative or radiological procedure, the other had a simple vulvectomy. Both died within 6 weeks. Mortality 100%. This record should be much improved in the future. The opportunity for early diagnosis is apparent and with radical treatment a large percentage of these patients should have five-year cures.



The three cases of carcinoma of the ovary have an average age of  $57\frac{3}{4}$  years. The average time elapsing between their symptoms and admission to the hospital was 4 months. The mortality, like that of the vulva, was 100% — all being dead within 16 months. The operative procedures consisted of one bilateral salpingo-oophorectomy, one left oophorectomy, and one case was considered inoperable. None of them received any radiation, because none was available at the time, and radiation is not of great value in these cases.

The four cases of carcinoma of the fundus had an average age of  $58\frac{1}{2}$  years. Their chief complaints in the order of frequency were vaginal bleeding, present in 50%; leucorrhea, present in 25%; and abdominal pain, present in 25%. The average time elapsing between onset of symptoms and admission was 13 weeks. Their treatment consisted in supra-vaginal hysterectomies with bilateral salpingo-oophorectomies, with the exception of one, who was considered inoperable. The mortality at the end of five years was 75%.

The 7 cases of carcinoma of the cervix averaged in age  $54\frac{1}{2}$  years. The time elapsing between the first symptom and admission to the hospital was five months. The symptoms in order of appearance were bleeding in 60%, leucorrhea in 20%, pain in 15%, and a lump in the vagina in 5%. The treatment consisted in nothing but a biopsy in five of the cases. They were all dead within 2 years. One had a vaginal hysterectomy and was dead in 20 months. The seventh case was referred to the Hartford Hospital for treatment and is alive today. A five-year mortality of almost 86% constitutes this group, which is not a very enviable record when it is considered that this cancer offers one of the best opportunities for cure, and that the clinics report an average cure rate of all cases for 25%.

It is very interesting to note that in the last five years the number of cancer cases of the female generative tract is exactly  $2\frac{1}{2}$  times that of the first five, and that in view of the fact that the population of the city has remained about the same. We take this to mean: more careful diagnosis on the part of the doctor; more interest in cancer on the part of the public due to cancer education. We have more equipment

and personnel with which to fight now and we look forward to the future with confidence. We have no apologies for the past, we did the best we could with what we had.

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## A BRIEF REVIEW OF UROLOGICAL MALIGNANCIES IN NEW BRITAIN GENERAL HOSPITAL DURING THE PAST 10 YEARS

R. W. Pullen, M.D., New Britain, Conn.

This paper undertakes to review quite briefly the urological malignancies in the hospital during a period of ten years. The group reviewed is rather small, consisting of fifty-five cases. In making a review of this sort one is liable to find himself so enthralled by the sheer beauty of statistics that he may draw unjustifiable conclusions. For that reason it has appeared to me that a paper consisting of a minimum amount of statistical data, combined with some recital of selected cases and a few tentative conclusions, might most satisfactorily answer its intended purpose. Statistics of course there must be, but they will be as brief as possible.

The cases divide themselves readily into five groups: Carcinoma of the prostate, carcinoma of the bladder, nephroma, carcinoma of the female urethra, and carcinoma of the penis.

The largest group comprises the carcinomas of the prostate gland. Of these there are 25. Of that group 5 are alive and 20 dead. In the main these cases upon admission were in relatively poor condition and treatment was attempted as effectively as seemed possible to each case. 11 prostatectomies were done and of these 5 survive. 6 are dead, their span of life having extended from 4 months to 14 years. Purely palliative cystotomy was done in 5 cases. All of them died in from 4 days to 5 months. These cases comprise a group nearly moribund on admission. There are 8 cases in which no operative work was done. These are likewise all dead, having lived from 11 months to 5 years. One patient in whom a palliative transurethral was done lived for 3 months. Grossly then one finds that there are living today 5 cases whose average life since operation is 3.2 years. 20 cases died and their average life post-operatively was  $2\frac{1}{2}$  years. The picture thus presenting itself is

indeed very grave. In retrospect however there are a few encouraging facts. A brief resume of one case in particular will illustrate what I have in mind. One patient, Mr. W., 62 years of age, presented himself for prostatectomy and after examination was found to be in good condition for operative procedure. Clinically he did not appear to have prostatic malignancy. A two stage prostatectomy was done from which the patient recovered uneventfully. Pathological study however revealed that the specimen was malignant. After some consideration it was decided to give him a full course of deep therapy. This was done and he remained in good health up to a few weeks before his death, which occurred 4 years after operation. Fortunately an autopsy was obtained and it was found that the site of operation showed no recurrence, the patient having died from metastases elsewhere. The interesting point to me in this case is that deep therapy had apparently succeeded in controlling the local condition entirely. The disappointing part of the case is, however, that in spite of local control by deep therapy the patient ultimately died from metastases which must have existed prior to operation but which were not discoverable by clinical or x-ray means. It is also interesting to note that of the 8 patients upon whom no operation was done life extended from 11 months to 5 years after diagnosis of carcinoma of the prostate.

The review contains 18 cases of carcinoma of the bladder. Of these 9 still live and 9 have died. The length of life in those living has been from 4 months to 7 years, averaging  $2\frac{1}{2}$  years. Of those dead, life continued for from 3 days to 5 years, with an average of 1.3 years. In this group of cases treatment varied considerably and here again choice was suited to the case insofar as seemed possible. 5 were treated with radium emanation seeds, platinum filtered, of the non-removable type, either through a cystotomy wound or by cystoscopy. Of these 4 are alive, the period of life from 2 years to 7 years. One died 4 months after implantation of radium. Two cases were treated by fulguration alone. These are relatively recent cases, were seen very early and have been perhaps the most completely observed of any to date. One of these is now 4 months post-operative and the other 1 year. Both show no evidence of recurrence, their bladders appearing entirely normal. 4 were

treated by deep x-ray therapy alone. 2 of these lived and 2 have died. The span of life in the living has been 1 year and 2 years respectively, and the post-operative life in the others, 1 year and 2 years respectively. There are 6 cases in which no operation of a curative nature was attempted as they were considered inoperable at the time of diagnosis. Of these 1 lives after  $3\frac{1}{2}$  years and 5 have died in from 4 months to 8 years after operation. In one case excision alone was performed and the patient died 1 year after operation.

Reviewing this small group then one sees that the most encouraging results were those seen in the patients who had radium treatment. The results of fulguration are yet too recent to be evaluated. 3 cases treated with radium are particularly interesting. One, a man 69 years of age presented himself complaining of hematuria. He had an apparently benign prostatic hypertrophy and multiple carcinomata of the bladder. Biopsy classified these as of a Grade 2 malignancy. Radium implantation calculated to give a dosage of 4,800 millicurie hours resulted after a rather stormy post-operative course in apparent cure. This patient is alive and apparently well after  $3\frac{1}{2}$  years. It is interesting to note that about 4 months after his bladder trouble he was obliged to return to the hospital for a gastro-enterostomy for causes not related to his bladder condition. He successfully underwent that operation and claims today to be in better health than he has been for a good many years.

A second case, a woman aged 32, presented herself complaining principally of hematuria, and a squamous cell type of carcinoma involving the floor of the bladder was found. This has been treated with radium implantation and at the end of 2 years and 9 months the patient shows no evidence of malignant extension, but is apparently suffering from a trophic ulcer at the site of her previous tumor.

The third case was a man 60 years of age whose chief complaint was hematuria. He had a rather large fungating tumor which was excised and treated by repeated radium emanation implantation. This patient's initial operation was done 6 years and 10 months ago. At the present time he is alive and apparently well. Examination of his bladder 6 months ago revealed some cellular debris in the floor of the bladder but no evidence of malignancy extension.



In the review there are 9 nephromas. Of these 4 now live from 2 to 5 years after operation with an average of  $3\frac{1}{2}$  years. 5 are dead, death having occurred from 1 to 4 years after operation, averaging 3.2 years. The data available on 8 of these cases is complete. One is of little value since dates are not obtainable. One knows only that the patient was seen and not operated on about 8 years ago and has since died, but when is unknown. In the remaining 8 cases on which complete data appear 8 nephrectomies were done. 4 of the patients are alive and well. 4 are dead. In the living cases, which vary in duration from 2 to 5 years, all are apparently without extension or metastasis. Analysis of cause of death in the 4 who have died shows that all but one death is traceable to extension of malignancy. One was due to a cerebral accident occurring 3 years and 9 months post-operatively.

Two of the nephroma cases were rather interesting. One occurred in a woman aged 53 who entered the hospital complaining of a large mass in her right flank which she had first noticed 15 years before. Examination at the time of admission revealed that this tumor of which the patient had been conscious for 15 years had grown to such size that it occupied the entire right half of the abdomen. Its great size somewhat complicated the business of diagnosis. However a pyelographic diagnosis was made and nephrectomy performed. The mass removed was truly enormous but rather surprisingly the patient's post-operative course was not particularly stormy. She is alive and apparently well 2 years after operation.

A second case, a man 43, presented himself with hematuria. Pyelographic study revealed a nephroma and nephrectomy was done. Post-operative course was uneventful for 4 years but hematuria then recurred and examination showed recurrence in the ureteral stump. Subsequent study led to the belief that there was recurrence in the renal area also. At this time an entirely new and rather untried method of treatment was attempted at the patient's request. He was given a course of ensol under the direction of Dr. Allen in Hartford Hospital. The case terminated fatally 4 months later having shown no improvement under ensol therapy.

The remaining cases of the group may best be considered individually. One is a carcinoma of

the female urethra in an elderly lady, the duration of which was impossible to determine though it is suspected to have existed for months, if not years. Excision was followed by symptomatic relief but not by cure, the patient dying 1 month post-operatively.

The remaining 2 cases are carcinoma of the penis, one in a man 49 years of age who refused operation but lived for  $1\frac{1}{2}$  years. The other in a man 62 years of age who had an enormous fungating growth with complete destruction of the organ and involvement of the inguinal nodes. He also suffered from lues and numerous cardiac difficulties. Operation upon him was undertaken with the utmost trepidation with little hope of success. The patient, however, begged that something be done to relieve him temporarily. Amputation of the penis was performed without appreciable difficulty and with no apparent shock to the patient. Just at the close of operation, however, he suddenly went bad and died an almost immediate cardiac death.

It was stated at the beginning of this paper that any attempt to draw conclusions from so small a group was probably not justifiable, but in reviewing the situation briefly one would be rather forced to conclude that thus far we have not satisfactorily solved the problem of carcinoma of the prostate. Undoubtedly one very important reason is that the patients have presented themselves quite late in the disease. There have been but few cases in which hope of cure existed at the time of operation. It does appear, however, that prostatectomy has prolonged these patients' lives considerably. Palliative cystotomy has of course been unsuccessful since it was done only in those cases which were already well nigh moribund and relief of pain was the primary consideration. The present treatment of choice here for the carcinomas of the prostate is prostatectomy followed by deep x-ray therapy in cases which seem at all operable and purely palliative treatment in those cases which seem inoperable.

In carcinoma of the bladder radium appears to offer perhaps the best hope, particularly in those cases which are moderately advanced and surely most of the cases which we see are that far advanced. In early cases it appears that fulguration is very definitely good, particularly if carried out under anesthesia so that it can be done thoroughly. The 2 cases in this review

thus treated have responded very well indeed. Of course the period of post-operative observation has not been sufficiently long to draw permanent conclusions. This much can be said however. Thus far the apparent completeness of the cure has been rather surprising. Both cases were proven malignant with biopsy yet fulguration has not only destroyed the tumor but has restored the bladder mucosa to such a degree of normalcy that were an urologist to examine these bladders without the knowledge of previously existing tumors I am sure he would find no abnormality.

With regard to nephromas there seems to be relatively little indecision as to the proper immediate procedure. Nephrectomy is undoubtedly indicated, to prevent exsanguination, if nothing else. Whether this should be followed by deep therapy appears to be a debatable point.

In conclusion, it is to be hoped that the institution of tumor clinics throughout the state will be [of very material help in bringing malignancies to early attention, and in enabling more energetic and forceful follow-through.

### GENERAL DISCUSSION

*Dr. Charles L. Larkin, Waterbury*, chairman of the Association, expressed appreciation to Dr. Rosahn and his colleagues for the excellent program. He called attention to what the Association had accomplished in the four years since its formation and expressed the opinion that where radium is not available in any community it should be purchased by the physicians interested in cancer work.

*Dr. Ralph E. Kendall, Hartford*, complimented the New Britain Tumor Clinic on its follow-up.

*Dr. Willaim Stone, Norwalk*, emphasized the good effect the tumor conferences are having on the entire hospital.

*Dr. John H. Watkins, New Haven*, called attention to the fact that the chief value of

Dr. Rosahn's paper is in the use of significance tests and in the statistical task of attempting to relate his data back to the population from which it came.

*Dr. R. F. Hertzberg, Stamford*, informed the Association that the attendance at the tumor clinic in his hospital is better than at the regular staff meetings.

—☆☆—

### LEGAL ASPECTS OF CHRISTIAN SCIENCE

A book by the above name has been prepared to serve as a guide wherein the legal aspects and interpretation of Christian Science are entailed. Such items as the following are fully considered, and illustrative legal cases cited; Christian Scientists can testify in court, but are disqualified as jurors wherein personal injury, human physical injury or illness, and mental anguish are issues: neglect to call medical or surgical aid, when indicated, reduces amount of recoverable damages, regardless of religious beliefs; Christian Science practitioners are liable for malpractice only as are other practitioners — for failure to render care according to the usual standards of their respective order; divorce may be granted on the ground that the mate is a Christian Scientist and children for obvious reasons may be awarded to the one who is not; many states eliminate Christian Scientists from their medical practice acts but require them to conform to health regulations in presence of epidemics or catastrophe wherein their nonconformity would endanger others.

Such facts should be understood by insurance carriers, compensation funds, health authorities, doctors, and medical societies whenever the issues arise. The author is I. H. Rubenstein of the Chicago Bar and the publishers The Cran-don Press, Chicago.

*Rocky Mt. Med. Jour. April 1939*

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# State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

## The Connecticut Mouth Hygiene Program

FRANKLIN M. ERLNBACH, D.M.D.,\*  
Hartford, Conn.

The Division of Mouth Hygiene in the State Department of Health has been carrying on activities since September 1924. From a modest beginning, the work and scope of the Division has steadily increased and expanded until now the personnel numbers five full time dental hygienists, all graduates of recognized schools of dental hygiene and registered by the Connecticut Dental Commission, and a full time dentist who has had post-graduate work in public health administration.

From its inception the objective has been to disseminate information along the lines of prevention. As early as 1900 it was recognized by some of the leading men in the dental profession that reparative dentistry was not going to solve the problem of dental caries, nor even keep abreast of it. There was a suspicion then that education of the public was needed so as to implant the seed of prevention in their minds. Today we know that prevention is the key word along all fronts of both medical and dental endeavors.

The program of the Division as it is now constituted is a purely educational one having as its aim the prevention of defects and the referring of children to their family dentists for early correction of defects. The educational phase of the program is directed toward four fields: prenatal; preschool; school; adult.

In the prenatal group our educational endeavors are truly preventive, in that from month to month prospective mothers are supplied with information which is pertinent to the several stages of development during pregnancy. One lecture is devoted to the growth and development of the dental structures and is of considerable value because it is material which is of immediate

interest to the prospective mother. Deciduous tooth formation begins at the seventh fetal week and calcification of the crowns begins about the seventeenth fetal week and is complete at birth. The permanent teeth begin to form at the seventeenth fetal week and their crowns begin to calcify about a month before birth. If sound dental structures are to be obtained it must be during the period of formation. Adequate and abundant tooth-building materials must be present and any interruption or inadequacy will ultimately become apparent as hypoplasia, defective fissures or enamel, or disarrangement of the teeth in the jaws. These facts and their implications should be fully understood by obstetricians and pediatricians as well as dentists.

In the next phase, the preschool stage, the pediatrician is in a key position to influence the mother. Regular examinations during infancy will undoubtedly reveal many minor imperfections or tendencies which if corrected immediately will alleviate the necessity for more radical procedures later in life. By the same virtue, this procedure is bound to reflect itself in sounder dental tissues since this is an important period in tooth development. By the time a child has reached the age of two years the deciduous dentition is nearly complete and the buds of most of the permanent teeth are in place and in the process of calcification. This is the ideal time for the mother's attention to be directed toward dental examination and correction of dental defects if needed. In the State program the contact with the parent is made through the child's attendance at Well Child Conference. Here the objective is the limitation of the extension of carious lesions and the prevention of loss of tooth structure, by early visits to the den-

\*Chief, Division of Mouth Hygiene.

tist. Health habits formed during the preschool period are rarely forgotten and the pediatrician can be of inestimable value by throwing the weight of his influence toward early correction of dental as well as physical defects.

In the school group our attention is directed primarily to the children in the first three grades. The reason for the concentration of effort is obvious. A child entering school usually has the four sixth year molars in place in the mouth. These teeth are known as the keystone teeth of the permanent dentition. When erupted normally and upon assuming their proper places in the arch they establish a relationship between the jaws known as normal occlusion and maintain that relationship during the time a child is losing the deciduous teeth and erupting the permanent ones. It is a known fact that of all the permanent teeth lost before fifteen years of age, ninety-five per cent of them are sixth year molars. This shows the importance of stressing early dental attention at this time so as to make a real attempt to retain more of these important teeth for future use. Another important point in connection with the early loss of any of the teeth is the resultant malocclusion which predisposes to diseases of the periodontium in later life. From the standpoint of health care, what more promising time can be found for health education than the period between six and ten years of age? Our program is built around four principal items, (1) proper dietary requirements for the growth period, (2) home care of the oral cavity and its contents, (3) well regulated personal habits to maintain vigor and health, and (4) regular semi-annual visits to the dentist. Through the co-operation of the Department of Education, the dental hygienists visit the schools, set up their portable equipment and make dental inspections and give prophylaxes. This service is secondary to the educational program and is meant to demonstrate the relationship between oral cleanliness and health care.

It is interesting to note that the majority of children of all ages are pretty well informed re-

garding health care and the necessities for promoting normal growth and development. Resistance is met in the homes through lack of knowledge of the facts, carelessness, or economic inability to carry out those measures known to them. This is a real and difficult obstacle to overcome. We can only look to the future when the children whom we are now instructing have homes of their own to solve this problem. In the meantime student groups such as student nurses and student teachers, both potential influences in the home, are receiving an increasing proportion of our time and effort. Visiting nurse associations, dental hygienist associations, post-graduate courses for teachers are all included in our educational efforts and soon we hope to conduct refresher courses for dentists in pedodontia. Another fertile field for dental health education is through contact with such adult groups as parent-teacher associations, women's clubs, Kiwanians, and Lions.



#### WARNS AGAINST USE OF BENZEDRINE

The use of benzedrine in place of alcohol for the purpose of "pepping up" or getting a "kick" out of its effects should be discouraged, *The Journal of the American Medical Association* for March 11 warns.

Commenting on recent experiments by an eastern physician with the use of the drug in place of liquor for cocktail parties, as a possible cure for habitual drunkenness, *The Journal* says:

"The Council on Pharmacy and Chemistry of the Association within the last year has published a report, 'The Present Status of Benzedrine Sulfate,' which has a considerable number of warnings concerning the use of this preparation by the general public.

"There are several other features apparently overlooked (by the physician who made the experiments), among them the fact that, while alcohol is a dilator of blood vessels, benzedrine constricts them."

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(SEE PAGE 2.)



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**MANUSCRIPTS.**— Manuscripts should be type-written, double-spaced, on white paper  $8\frac{1}{2} \times 11$  inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

**ILLUSTRATIONS** — Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct: drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

**NEWS.**— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

**ADVERTISEMENTS.**— All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

**SUBSCRIPTIONS.**— Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

**REPRINTS.**— Reprints of papers and obituaries may be obtained from the Editor at cost.

## • Editorials •

### PREPAYMENT MEDICAL CARE

With the passage in the recent session of the General Assembly of House Bill 857, an Act concerning Medical Service corporations, the attention of the profession in the State has been focussed upon prepayment medical care. Prepayment hospital service plans have been in operation in this state for some time. The public enrolled with eagerness and with the corporations soundly constructed and judiciously operated under the control of the insurance commissioner there has been almost universal satisfaction. The basis for the establishment of prepayment medical care presents a more complex problem. No data has been available to aid in setting up such a plan. Because of this fact and also because of the foresightedness of the Council, our Society has had a committee studying the problem and collecting factual data against the day when it may see fit to engage in or support a plan for prepayment medical care.

The development of methods for organizing payments for medical services has been a subject of much controversy, especially since the depression years beginning in 1930. Organized medicine has been considered by the laity as opposed to such plans for group payment of medical bills, chiefly on the ground that anything of this nature was classed as socialized medicine. The evolution of plans for prepayment of medical services has been rapid, augmented to a great degree by the demands of the public which expected that when hospital service plans were put in operation, medical care would be included.

Prepayment or group payment medical service plans as supported by medical societies fall into two types, those on a unit service basis and those on a cash indemnity basis. The details of operation vary in different parts of the country. Under the unit service plan a schedule of the number of units to be allowed for each service is established and the value of the unit is determined by dividing the amount of money available for medical bills by the number of units of service rendered. Under the cash indemnity plan benefits are paid according to a listing of benefits which

limits the amount that can be paid to the member or on assignment to his physician. The cash indemnity method does not fix the physician's fees but does assist the member to meet his medical bills. The unit service plan appeared first in the states of Washington and Oregon. The California Medical Association has set in operation a state wide plan of the unit service type. The Fulton County (Georgia) Medical Society, the Cincinnati Academy of Medicine and the City of San Francisco have all sponsored unit service plans. Many difficulties have arisen with this type of prepayment medical care. Fees have been reduced in some instances to a point where participating physicians complain that they do not receive sufficient remuneration to enable them to practice good medicine. No allowance is made for differences in ability among physicians of like training. It has been found difficult to determine an income status for the group to be included in the unit service plan.

Voluntary medical expense insurance, as its name implies, is a voluntary insurance plan through which a person may obtain a certain amount of money with which to pay the costs of necessary medical services. The amount of the benefits available depends upon the amount of the premium paid, as in any insurance plan. The House of Delegates of the American Medical Association at its 1938 session put its seal of approval upon cash indemnity plans for medical service.

The Medical Society of the State of New York has been interested in a medical expense indemnity plan. Amendments to the New York State Insurance Laws were passed by the recent session of the Legislature, thus making possible the operation of medical service plans under these laws. The Legislature of the State of Michigan in May passed House Bill 215, an act to provide for and to regulate the incorporation of non-profit medical care organizations; to provide for the supervision and regulation of such corporations by the state commissioner of insurance; and to prescribe penalties for the violation of the provisions of this act. The Medical Society of New Jersey voted at its annual meeting in June to establish a non-profit corporation to provide group medical ser-

vice under an insurance system, with all the subscribers paying at the rate of about four cents a day. Legislation prepared by the Medical Society of the State of Pennsylvania was passed by both Senate and House of Representatives and signed by the Governor on June 28 authorizing doctors of medicine to render medical services on a cooperative plan at a low cost to voluntary subscribers. Persons of low income in Pennsylvania may now buy medical services at a low cost, thus providing themselves with adequate medical care. The plan contemplated in the bills has no relation to or connection with socialization of medicine, according to the Pennsylvania Medical Journal, nor does it have any connection with compulsory health insurance. The West Virginia State Medical Association has taken under consideration a plan whereby low income groups can prepare for sickness emergencies through the payment of small monthly sums entitling them to hospitalization, medicines, nursing, medical and surgical services while in hospitals. The Utah State Medical Association has endorsed a plan of combined hospital insurance and cash indemnity for a limited amount of medical care.

Only in Ohio do we find the 1939 Legislature refusing to enact an enabling bill (Senate Bill 104) sponsored by the Ohio State Medical Association whereby the physicians of any county may start group medical service plans. Opposition to this bill came from many physicians, from conservative members of the General Assembly who regarded the proposal as socialistic in character, from osteopaths and limited practitioners, from farm and labor groups, from some insurance interests and from some members of the Legislature who were inherently anti-medical.

The Connecticut State Medical Society is now in a position, when opportunity offers, to demonstrate that organized medicine, at least in this State, is not blocking the introduction of medical care at lower rates. No actual contract has yet been drawn but the bill provides for the form of the contract and gives the insurance commissioner authority to refuse approval if he finds the rates are excessive, inadequate or discriminatory. In the words of our Executive Secretary, our Society and its components has a genuine opportunity to meet one of its greatest responsibilities.



## FIFTEENTH CLINICAL CONGRESS of the

Connecticut State Medical Society  
New Haven, September 19, 20, 21, 1939

The many expressions of approval of last year's program, particularly in reference to the five minute talks and the special courses, have led the committee to plan this year's Congress along similar lines.

The morning sessions will be devoted to addresses by visiting speakers, with the five minute talks coming late in the morning. Panel discussions and the special courses will be held in the afternoon.

The evening meetings are being arranged by the various sections. These meetings are open to all members of the Congress.

The fee for the Congress will, as usual, be \$2.00. This fee covers all sessions excepting the special courses. Members of the Congress may register for one of the special three day courses by paying an additional fee of \$1.00.

The Women's Medical Society of Connecticut will hold its fall meeting at the time of the Clinical Congress. All women in medicine will be welcome. Further details will appear in the final program.

Parking of automobiles for members of the Congress will be unrestricted as to time in the vicinity of the meeting place. Continuous telephone service will be maintained. The telephone numbers will be announced in the final program.

Early registration will facilitate the work of the committee, save time for you at the Congress and assure you of a place in the course for which you wish to register. Registration cards have been mailed with the preliminary announcement. If you did not receive one or have mislaid yours, your registration will be accepted now if you will send your name and address together with your check for \$2.00 (\$3.00 if you are registering for one of the special courses) payable to the Connecticut Clinical Congress. This should be sent to Dr. Maurice J. Strauss, 41 Trumbull Street, New Haven, Connecticut. Names of all who register before August 25th will appear in final program to be distributed about September 1st.

M. J. S.

## FEDERAL GOVERNMENT IN MEDICINE

The National Grange Monthly makes a smart point in a recent discussion of socialized medicine in the United States. The Grange says: "If giving the Federal government all power in the domain of medical care could be expected to alleviate or cure the ills with which we are afflicted, then Washington, the Capitol City of the Nation, should be a model in this respect. In Washington, the will of the Federal government is supreme; it can do as it pleases, without let or hindrance from any outside source; its fiat is law.

"Under the circumstances, it is constructive to note that for the year 1936, the death rate from cancer was 26 per cent higher in the District of Columbia than the average rate from this disease throughout the United States. In the case of heart disease, the death rate was 27 percent higher than the general average of the nation as a whole; 49 per cent higher from pneumonia; 92 per cent higher from tuberculosis; 106 per cent higher from alcoholism, and 119 per cent higher from syphilis. The vital statistics for the nation further disclose the fact that the infant mortality rate in the District of Columbia is 26 per cent higher than that of the whole United States, while the maternal death rate is 91 per cent higher."

Any one who knows his Washington knows it is not all Cherry Blossoms and DuPont circle and that there are great slum areas crowded with poor and illiterate. But on the whole the city is populated by people from all over the nation who should have been chosen because of their intelligence and skill in government. And presiding over it all is an administration that would revise the pattern of medical care for the whole country. One is moved to the idea that if the Federal government feels impelled to improve medical care for the people of the United States the District of Columbia would be a good place to start.

C. B.



## RICHARD CLARKE CABOT

It is but fitting that we add our tribute to the memory of one of the greatest members our profession has produced during this century. Teacher, scholar, musician, religious worker, leader in medical social service, as well as renowned in the field of internal medicine, Dr. Richard Cabot stood as an ideal for many a young medical

student and practitioner to strive after. Boston rightly boasted of his presence.

Dr. Paul D. White has so aptly described Dr. Cabot's attributes in the *New England Journal of Medicine*, June 22, 1939, that we quote his opening paragraph:

"In every generation there are restless souls, who cannot be made to fit the common mold. A few of these are valuable in keeping their communities and professions in a ferment by their constant challenge to the existing order of man's thought and action. But when, in addition to possessing these attributes, a rare individual is endowed with the divine fire and makes important contributions to the pioneering progress of humanity, then indeed we recognize a great leader. In the thick of the fray such recognition comes slowly but as the smoke of the battle clears the acclaim is universal."



#### DANGERS OF PREGNANCY AFTER LONG INTERVAL

Women who have not had a pregnancy for ten years or more should receive the best pre-delivery care and should be delivered in a hospital under expert obstetric supervision, *The Journal of the American Medical Association* for April 1 says in an editorial.

"The impression that women who have long intervals between pregnancies are especially prone to obstetric difficulties and complications induced Margaret B. Ballard to study 100 unselected pregnant women who had not had a pregnancy for ten or more years," *The Journal* says. "Ninety per cent of the cases were from the clinic group, and the other 10 per cent from the private practices of the clinic staff. There were fifty-six white and forty-four colored patients, approximately the reverse ratio of the white and colored patients on the service. Eighty-five were between 26 and 40 years of age and forty were between 31 and 35.

"The average interval between pregnancies was 12.38 years and in 80 percent the elapsed period between the present and previous pregnancies was between ten and fourteen years. Two patients, however, reported intervals of twenty-one years. Altogether, these women had experienced 207 previous pregnancies, fifty had

#### IMPORTANT NOTICE

#### WORK PROJECTS ADMINISTRATION EMPLOYEES' COMPENSATION PANEL

The Works Projects Administration for Connecticut has asked The Connecticut State Medical Society to cooperate with it in making an equitable distribution among the physicians of the State of the cases of employees in the Work Projects Administration who receive traumatic injuries in the performance of duty.

There are two functions that the Administration would like the State Medical Society to carry out.

1. The preparation of a list of physicians in the State who are interested and willing to participate in the care of injured Work Projects Administration employees under the regulations of the United States Employees' Compensation Commission.
2. A monthly review of the distribution of such cases among physicians with the view of making that distribution fair and equitable.

To accomplish this, members of the Society who wish to participate in the care of injured Work Projects Administration employees are asked to register in the office of the Secretary of The Connecticut State Medical Society. The names of these physicians will be placed on a panel of physicians in each locality. This panel will be available to the local Work Projects Administration Supervisor and he will refer injured employees to such physicians for treatment.

Many members of the Society are already registered with the Administration for this purpose, but in order that we may have a complete list of physicians who wish to take part in this activity they are asked to register again with this office, on the form that is given below. It is understood that there is nothing obligatory about this and if you do not wish to participate, you need do nothing about it.

In addition it is proposed that a consolidated record of the cases referred to physicians throughout the State be reviewed each month by a representative of the Society to determine if the cases have been assigned in a reasonably even manner so that, insofar as is



possible, all physicians on the panel will receive an equal amount of this work.

Those of you who are already familiar with Work Projects Administration compensation procedure know that there are several forms that must be submitted in connection with each case. Others who have not, up to now, done any compensation work for the Work Projects Administration should become familiar with the administrative procedure and inquiries with respect to it addressed to this office will be promptly and fully answered.

In undertaking this activity for the Work Projects Administration it is clearly understood that The Connecticut State Medical Society will have no authority to pass upon or approve physicians' charges. Likewise the local Work Projects Supervisor or the State Administrator has no authority to adjust those charges. The United States Employees' Compensation Commission has sole jurisdiction over these cases as to the approval of the case and payment for services rendered.

Members of the Society who wish to be placed on the panel to participate in this activity are requested to fill out the form printed below, detach and mail it to The Connecticut State Medical Society, 258 Church Street, New Haven, at once in order that panels may be set up at an early date.

Creighton Barker, M.D.  
Executive Secretary

## DANGERS OF PREGNANCY

(Concluded from Page 427)

one prior pregnancy each and one woman had had nine previous pregnancies.

"Eighty-seven patients delivered full-term living children and there were twelve deliveries of premature children, including one set of twins. The average duration of labor of ninety-three patients who were allowed to go into labor was slightly over twelve hours. Sixty-two patients had labor of ten hours or less, while twelve had twenty-four hours or more of labor. There were sixty-eight normal spontaneous deliveries, six cesarean sections and seventeen forceps deliveries.

"It was also concluded that white women are more apt to have long intervals between pregnancies than colored women; there is no difference between the longer and shorter intervals as to labor complications; the number of full term living children is slightly increased; the average duration of labor is increased about one-fourth; operative deliveries are increased more than three times; the ratio of male to female babies is increased over the average, and (various) complications . . . are definitely increased. She concludes, therefore, that the woman who has not had a pregnancy for ten years or more should receive the best antepartum care and should be delivered in a hospital and under expert obstetric supervision."

Tear Here

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# From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street

New Haven

## Annual Meeting 1940

The 148th Annual Meeting of the Society will be held in Hartford on May 22 and 23. The House of Delegates will meet on Tuesday, May 21. The Hartford County Medical Association has appointed the following Committee on Arrangements for that meeting:

T. W. Worthen, <i>Chairman</i>	Hartford
B. B. Robbins	Bristol
W. T. Morrissey	New Britain
D. C. Y. Moore	Manchester
E. J. Turbert	Hartford
C. B. Brainard	Hartford
P. J. Steincrohn	Hartford
F. T. Oberg, <i>ex-officio</i>	Hartford

The Secretary of the Society met with this Committee on June 19 to make preliminary plans for the meeting.

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## Doctor Brown to be member of the Committee on Cooperation with the Yale School of Medicine.

At its June meeting the Council selected Doctor D. Chester Brown of Danbury to succeed the late Doctor Ralph A. McDonnell as a member of the Committee on Cooperation with the Yale School of Medicine.

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## Law Governing Medical Service Corporations

House Bill 857, An Act Concerning Medical Service Corporations, introduced by the State Medical Society and passed by the General Assembly has been signed by Governor Baldwin and is now law. It is an act enabling the organization of non-profit corporations for the purpose of underwriting the costs of medical care. The incorporation of such enterprise must have the approval of the Commissioner of Insurance of the State and, in his opinion, be in

the public interest. Supervision of the finances and administration of these corporations is vested in the Commissioner of Insurance. In a recent radio broadcast Governor Baldwin mentioned this law as one of the important pieces of social legislation passed by the 1939 General Assembly.

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## Annual Meeting Questionnaire

The questionnaire seeking information concerning the program for the annual meeting that was sent out in June received an enthusiastic response. About six hundred members of the Society have already returned their answers. This number is about equally divided between those who attended the meeting and those who did not. The opinions derived from the replies are interesting and instructive. An analysis is now being made of the returns and will be published in a later issue of the Journal so that all may know what our members think about the annual meetings. All of the information collected will be given to the Society's Program Committee for its guidance. It is encouraging to note that more than one hundred members expressed a willingness to cooperate in the arrangement of future programs.

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## A Study of Prepaid Medical Service

The Committee appointed by the President to study prepaid medical service has had its organization meeting and the program for the scope of its study has been formulated. The Chairman of the Committee is Doctor S. C. Harvey and the other members are T. P. Murdock, J. R. Miller, O. L. Stringfield and D. P. Griffin. A somewhat similar study has been made by The Medical Society of New Jersey under the direction of Doctor Norman M. Scott, Executive Assistant.



## SECTION ON Orthopedic Surgery

**Dallas, Texas — October 22-25, 1939.** The annual meeting of the International Society for Crippled Children in conjunction with the National Society for Crippled Children of the United States of America will be held in Dallas, Texas, at the Hotel Adolphus. An interesting program is scheduled and all orthopedists and workers with crippled children are urged to attend.

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**National Foundation for Infantile Paralysis.** A recent publication by the Public Health Service, Washington, D.C., shows that each year following the nation-wide appeal for funds to fight infantile paralysis there is received a shower of letters from victims suffering from other chronic diseases. Each letter states that the victim has given his dime for infantile paralysis control and wonders why funds have not been raised to find the cause and cure of their particular disease which is generally rheumatoid arthritis, chronic rheumatic heart disease, multiple sclerosis, spastic paralysis or other degenerative diseases. There are approximately seven million persons in the United States, according to the national health survey, suffering from rheumatism. This includes a host of children. The conclusion is obvious.

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**Be Prepared.** At a meeting of the orthopedic section during the Connecticut State Society's annual meeting in New Haven in the month of May, Dr. Spector, Chief of the Crippled Children's Division of the State Department of Health, suggested a plan for providing a central depot from which splints and other apparatus can be procured to use in cases of convalescing infantile paralysis. Such a depot or

reservoir of splints and apparatus has been organized in other states. The plan met with the approval of the orthopedic section. It is to be hoped that Dr. Spector will be able to carry out the scheme which will aid materially in the care of post-paralytic children.

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**Camps For Crippled Children in Connecticut.** Camp So-ka-li, Wilton, Connecticut, is open from July 1 to September 5 with a capacity of 50. Cardiac, anterior poliomyelitis and cerebral birth injury cases given particular attention.

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**Education for Physically Handicapped Children.** In 1937 reports made to the United States Office of Education and reported in Senate committee hearings indicated 22,906 physically handicapped children in the State of Connecticut in need of special education. These reports further indicated that only 792 were receiving the necessary special education required because of their handicaps.

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**Prize for Orthopedic Work.** Competition for the Umberto I. Prize was opened by the Rizzoli Orthopedic Institute of Bologna, Italy, January 1 and will close December 31. The prize is offered for the best "work or invention in orthopedics." Foreign as well as Italian scientists are invited to take part, according to an announcement. Application for information should be made to the president of the Rizzoli Institute, Bologna.

Plan now to attend the

**15th Clinical Congress**

at New Haven

September 19, 20 and 21, 1939

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A REPORT ON INSULIN SHOCK THERAPY  
TO THE BOARD OF DIRECTORS OF  
THE NEURO-PSYCHIATRIC IN-  
STITUTE AND HOSPITAL OF  
THE HARTFORD RETREAT

C. CHARLES BURLINGAME, M.D.,\*  
Hartford, Conn.

On a conservative basis insulin shock therapy, so-called, for the treatment of mental illness has been used at the Neuro-Psychiatric Institute of the Hartford Retreat for a long period of time but report on the results obtained from this form of therapy has been withheld until a sufficient number of cases have been treated and a sufficient period of time elapsed to indicate that more than a temporary remission was obtained.

More than 130 cases have so far received shock therapy, but included in the following summary of results are only those cases in which therapy has been definitely abandoned after a prolonged trial period, or in which complete or partial remission has been effective for at least several months. Recent cases which have shown improvement or those still under treatment are, therefore, not included.

Some of the cases included in the summary have been in remission for as long as two years without retrogressing, and all have been in the community for several months if listed as a complete remission.

“Complete remission” in the following table has been interpreted very strictly and includes only those cases where normality has been fully sustained, with full insight, and with no apparent lowering of intellectual function or reduction of social adaptation.

“Greatly improved” indicates that there has been a practical recovery, but without full insight, or with some lowering of intellectual or social functioning — but not to the extent that it interferes with a perfectly satisfactory adaptation to community life.

“Somewhat improved” varies in degree, from those who are able to make a community adjustment under controlled conditions, to those whose improvement within the institution has been noticeable.

“Unimproved” includes those whose condition apparently remained unchanged following prolonged shock treatment.

Of the total of 80 cases included in this summary, 22 made a complete remission, 9 improved greatly and were able to make a good social adjustment outside, 20 improved noticeably, and only 29 — less than one-third, showed no improvement.

The fact that more than 63% responded favorably to insulin shock therapy is not nearly as striking as the results obtained in analyzing the relationship between duration of the illness and total cure. When this is done, we find the following:

	Under 1 yr.	1-2 yrs.	2-4 yrs.	4-14 yrs.
Duration of illness	14	12	22	32
Total cases	12	3	5	2
Complete remission		2	3	4
Greatly improved	1	3	5	11
Somewhat improved	1	4	9	15
Unimproved	—	—	—	—
% Complete remission	85.7	25	22.7	6.2

It is obvious that the prognosis for complete remission is dependent in great measure on the duration of the disease process, and with more than 85% of those ill for less than a year making a complete remission in a few months time, the need for a general understanding of the desirability of early treatment for mental illness seems quite important.

These results are less impressive than the results obtained with the so-called chronic cases when one studies the results obtained with other forms of more intensive care as practiced here for the past eight years, where we have more than two members of the personnel for every patient. With such intensive care the percentage of remissions among the early cases was already very considerable without shock therapy.

Schizophrenia, in common with many other diseases apparently tends to become irreversible after a long period of time. However, mere duration of time is not a contraindication for the use of shock therapy-but quite the contrary. The occasional spectacular recovery of so-called chronic cases which have persisted for two years or more (and there are seven in this series) makes the use of insulin shock therapy on them almost imperative on the ground that all other forms of therapy have, presumably, been tried without

\*Psychiatrist-in-Chief



avail, and that any possible organic damage due to shock therapy might properly be chanced in view of the long persistence of the disease.

What cerebral damage follows as a sequel to insulin or metrazol shock is still more or less conjectural, but there is sufficient evidence to indicate that on recent cases of schizophrenia it is conservative to use other forms of therapy before resorting to insulin. One must not forget that before insulin there were other forms of therapy which frequently were successful in obtaining a complete remission and that psychotherapy, education and re-education, should not be abandoned in toto in favor of this newer therapy.

Treatment consisted of daily administration of insulin in units ranging from 20cc to 300cc, followed by a three hour period of hypoglycemia, at least one half hour of which is in deep coma. Experience has shown that it is not advisable to discontinue treatment even if there is no apparent improvement after as many as 50 treatments, as remission frequently does not occur until after the 60th or 70th treatment. This is at variance with the original practice which concluded treatment after about eight weeks if there were no ameliorative signs.

Typical of those showing complete remission, are the following cases:

A 39 year old physician admitted to the hospital March 22, 1938. Four years before he had been treated for an anxiety neurosis and recovered in three months. At that time he presented no definite schizophrenic (dementia praecox) symptoms. Since January 1938 a change in his personality was noticed. He felt that he was being watched and preyed on, and was in fear of being kidnapped; he had feelings of persecution. On admission he was very agitated and had many hallucinations. Insulin treatment was started May 5, 1938 with 20 units, first shock May 17 with 140 units at which time he was still very suspicious, felt that he was being confined by enemies and the insulin treatment was given him for experimentation. After 15 treatments, 5 shocks, he began to clear up and couldn't understand why he had felt persecuted. Began to remember the way various things had queer meanings for him; nevertheless he is still rather suspicious and rather seclusive in residence. From the 25th treatment on he progresses rapidly and becomes more agreeable, getting in good contact with his family. After 38 treatments, full insight, gives good description of the unusual experiences he had.

A 40 year old woman showed a definite change in her personality in August, 1935, became extremely irritable. Christmas 1935 she started to hear voices and had continuously the feeling that voices were transmitted to her sister by mental telepathy. Admitted to the hospital December 19, 1936. No improvement during stay in hospital and had to be tube fed for a period of months. In-

sulin treatment started May 22, 1938 with 15 units; on the 9th day of treatment went into hypoglycemic shock with 50 units. On the 18th day went into a very deep coma, and that afternoon seemed more relaxed than she had been in some time. Epileptiform convulsions on the 27th day with 25 units; after which she became slightly euphoric and spoke more freely. After 38 days of treatment definite improvement, she speaks freely about her problems, especially of her feelings prior to the inauguration of the shock therapy. Takes better care of her appearance which had been badly neglected. Marked improvement after 55 days. Had 7 spontaneous convulsions up to now. Full insight not gained yet but shows more interest in her environment, writes letters to sister; enjoys classwork and rarely hears voices. Has become very sensitive to insulin at this point and had a convulsion with 15 units on the 58th day. Delusions that she suffered from syphilis have vanished and she laughs about them but does not yet show full insight into her former psychological condition. From the 58th day of treatment on, her improvement progresses rapidly and during the following days she gains good insight. On the 61st day another epileptic convulsion occurred with only 10 units. Last day of treatment (62) with 6 units, and immediately after treatment is terminated she is slightly elated and rather talkative for about two weeks at which time her emotional condition became stabilized and she was discharged.

One must not overlook the necessity of good psychotherapy during the entire period of shock treatment, and it is a question whether or not one of the principal virtues of insulin treatment is that it makes the patient accessible to psychotherapy — but at any rate, if a permanent remission is to be obtained, shock therapy must be accompanied by good educational and re-educational therapy.

### Conclusion

1. While twelve out of fourteen cases of schizophrenia of less than one year's duration had a complete remission, the less frequent, but more unexpected remission of seven patients suffering for more than two years, indicates the advisability of using shock therapy on so-called chronic cases.

2. Other forms of intensive care should be given at least equal consideration with insulin shock therapy in early cases, because of the still undetermined possibilities of brain damage.

3. Under carefully controlled conditions, there seems to be no unusual hazard in administering of insulin shock therapy.

4. It would seem that de-education and re-education and other forms of psychotherapy are essential parts of any form of shock therapy particularly as the means of consolidating any gain.

# Our Neighbors

## MAINE

The Maine Legislature of 1939 passed two bills of interest to the profession. The first permits the sale of barbituric acid derivatives or compounds only on prescription, "except for personal administration by a doctor, dentist or veterinary to his patients." The second bill legalized the incorporation of the Associated Hospital Service of Maine (socialized hospital service).

The President-elect of the Maine Medical Association for the year 1939-1940 is Thomas Albert Foster, 2nd, of Portland. It is of interest to note that both Dr. Foster's father and grandfather served as presidents of the same Association, the former in 1884-1885 and the latter in 1907-1908. Dr. Foster is a graduate of Dartmouth College and of Harvard Medical School and spent two years as an intern at the Hartford Hospital before serving with British Hospital Number Twenty-two and the American Ambulance Hospital at Neuilly, France, during the World War.



## MASSACHUSETTS

Henry D. Chadwick, M.D., Waltham, Massachusetts, was elected president of the National Tuberculosis Association at its annual meeting held in Boston in June. Dr. Chadwick was also appointed a member of the Committee on Health Education of the Association for the year 1939-1940.



## NEW YORK

The 1939 Legislature of the State of New York acted upon several measures of interest to physicians. Chapter 778 of the Laws of 1939 prohibits sale of hypnotic and somnifacient drugs except on prescription and requires all containers to have label securely

attached by manufacture or jobber. Chapter 741 of the Laws of 1939 provides that persons licensed to practice osteopathy may be granted right to perform minor surgery and use anesthetics, antiseptics, narcotics, and biological products, upon proof of Regents of sufficient instruction and training; proof to be evidenced by credentials or examination. Chapter 892 of the Laws of 1939 requires the reporting of cancer and other malignant tumors by physicians to local health officers or State Commissioner; provides for a director of Cancer control division in the State Health Department, and appropriates \$35,000. The Piper Bill to recodify generally the Insurance Law, and including Article 9c, relative to medical expense indemnity insurance, was enacted into Law and has been signed by the Governor. This paves the way for non-profit voluntary medical expense indemnity insurance in this state. This system permits distribution of the costs of medical care over large groups without sacrifice of the benefits of private practice. The Physician's Lien Bill passed the Assembly but was defeated in Senate Judiciary Committee. All measures amending the Medical Practice Act, to provide better control over unethical advertising and other unethical conduct were defeated. Several radiology bills, sponsored or endorsed by the State Medical Society, were defeated. The bill to require full citizenship for medical licensure was defeated in Rules Committee in the Assembly and in Education Committee in the Senate. The Rules Committee also killed the Giordano Bill to require the allowance of free choice of physician to persons receiving home relief medical care.

The Westchester County Medical Society has established with the Westchester Pharmaceutical Association joint committees on Medical Pharmaceutical Relations for the purpose of bringing the two professions into a closer working relationship in this county. A permanent joint Board of Arbitration has been set up to receive and consider complaints from either pharmacists or physicians relative to alleged unfair practices or infringements of privilege on the part of the members of either profession.



## - NEWS -

### *from County Associations*

#### Hartford

Plans are going forward for the fall meeting of the County Medical Association which is to be held this year in New Britain at the Shuttle Meadow Country Club.

The committee on Workmen's Compensation for the first district consists of the following:

Dr. George W. Dunn, New Britain, *Chairman*

Dr. D. C. Y. Moore, Manchester

Dr. Benedict B. Landry, Hartford

Dr. Benedict M. Whipple, Bristol

Dr. Thatcher W. Worthen, Hartford

Congratulations to Dr. and Mrs. William F. Donovan on the birth of June Elizabeth and to Dr. and Mrs. Francis L. Lundborg on the birth of Francis Ludwig, Jr.

Dr. Wilmar Allen, Director of the Hartford Hospital, has been appointed by the Governor a member of a commission to investigate the Norwich State Hospital.

The annual meeting of the interne alumni of the Hartford Hospital was held on June 22. The morning was given over to clinics and ward rounds followed by lunch at the hospital. During the afternoon various sports were engaged in on the grounds surrounding the Avery Convalescent Home. Dinner was served at the Avery Convalescent Home.



#### Litchfield

Dr. Robert Walker, a 1937 graduate of the University of Rochester Medical School, on July 1 finished two years' internship at the Hartford Hospital and is now settled in Cornwall as assistant to his cousin, Dr. W. Bradford Walker.

Dr. and Mrs. John F. Kilgus, Jr., of Litchfield have enjoyed a two weeks vacation on the Eastern shore of Lake Champlain near Vergennes, Vermont.

Dr. and Mrs. Francis Sutherland, whose marriage took place in Baltimore on June 28, sailed the following Saturday on the Rex for two months travel abroad. Mrs. Sutherland,

the former Latna Mozelle Dalton of Pulaski, Va., is a graduate of Hollins College. They will be at home in Goshen, Connecticut, after September 1.

On June 21, Dr. Ralph Ogden of Hartford was the speaker at the final spring meeting of the Journal Club of the Charlotte Hungerford Hospital. Dr. Ogden's interesting talk on "Unusual Roentgen Findings" was illustrated by the appropriate films.

The Journal Club meetings will be resumed the middle of September and the program for fall and winter will be published in an early issue.

Due to local ordinances passed in 1938, towns of this vicinity report no serious fire-works accidents on July 4. In Torrington only one person required medical attention as contrasted to 1938 when there was one fatality, three serious accidents and twelve minor ones.

Dr. A. E. Childs, Health Officer, Town of Litchfield, reports further work in the Immunization Program against diphtheria and smallpox among the school and pre-school children. Nearly 90% of all the school children have been immunized successfully and had successful vaccinations.



#### New Haven

David R. Lyman, M.D., of Wallingford addressed the University of Virginia Chapter of Alpha Omega Alpha on April 1. He discussed "Some Aspects of Medicine Not in The Citadel."

Stanhope Bayne-Jones, M.D., dean of Yale University School of Medicine, recently was a guest of the faculty of the School of Tropical Medicine at San Juan, Puerto Rico, where he gave a lecture on "Recent Advances in Cancer Research."

The Clinic of Child Development of Yale University during 1938 received a grant from the General Education Board for the continuance of its work in observing, recording and defining the usual sequences of development as regards the normal activities of the child. The grant was also to aid the Clinic in using its schedules of progress to detect or interpret in possibly abnormal infants and children defects such as are found in developmental irregularities and in neurological or endocrine disease.

## Letters to the Editor

### A DISSENTING OPINION ON OPTOMETRISTS

Editor,

Journal of Conn. State Medical Society,  
54 Church Street  
Hartford, Conn.

Dear Doctor:

In the June 1939 issue of the Journal of the Connecticut State Medical Society, page 299, appeared an article entitled "Optometry and Ophthalmology." The statements made therein by no means express the consensus of Connecticut oculists on this important problem. I am entirely opposed to the general trend of the editorial and should like to challenge several of its specific assertions.

The statement that a course in optometry would adequately prepare a student to conduct an examination of the refraction and muscle balance of whomsoever applied is contrary to the best teaching of medical faculties in this country. In practically all children and in many adults the refractive error can be accurately determined only under cycloplegia. This entails the use of eye drops. Optometrists are prohibited by law from applying any medication to the eye.

Later, in comparing the optometrist to the ophthalmologist, it is said that the latter does not feel superior in the possession of an M.D. degree. On the contrary, that is just the reason why an oculist is superior. On completion of the course in medical school an M.D. degree is conferred. This gives the proper background on which to build a knowledge of a specialty, and only with this background is one qualified to be a specialist. How can some one without a medical degree attempt to treat any part of the body? Having the optometrist charge a fee for his examination

would in no way make up for the inadequacy of that examination.

It is stated that a great many people will prefer to be treated by an eye specialist (oculist) rather than an optometrist. These people are only a minority: in round figures 30% of the refractions are done by oculists and 60% by optometrists. The other 10% are done by peddlers, department stores, etc. The public health problem relating to 70% of the people seems worthy of more consideration.

The fact that optometrists outnumber oculists is no reason for not combating the evil. Our responsibilities as physicians demand that we protect the best interests of the public, even though these interests are threatened by a powerful group. Medical progress has had to fight opposition continuously and most eye physicians are ready to do their part.

Sincerely yours,

Frederick A. Wies, M.D.

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### THE DOCTOR'S OFFICE

Barnett Greenhouse, M.D., announces the removal of his office from 43 Trumbull Street to Dr. Sperry's building at 107 Whitney Avenue, New Haven.

Bernard Spillane, M.D., announces the removal of his office from 179 Allyn Street to 30 Farmington Avenue, Hartford, practice limited to urology.

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### A WEEKLY NEWSPAPER COLUMN

The Nebraska State Medical Association maintains a weekly column in the newspapers of that state. During 1938 this column went to 115 papers with a total circulation of 135,254. This means that this weekly message was read by approximately 608,643 people in the State of Nebraska each week. Its distribution now is practically statewide in the better weekly newspapers.

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## 147th Annual Meeting

### Proceedings — House of Delegates

(Continued from Page 386)

#### REPORT OF COMMITTEE ON MEDICAL EXAMINATION AND MEDICAL EDUCATION

Mr. President and Gentlemen of the House of Delegates:

The Connecticut Medical Examining Board admitted to its examinations during the past year one hundred seventy applicants. Of this number ninety seven took the written examinations and seventy three were admitted to the examination on the basis of credentials. There was a total of forty six failures or twenty nine per cent. Three osteopaths appeared for examination during the year: one wrote medicine, one wrote surgery and one wrote medicine and surgery. All three failed the examinations. There were two special meetings held during the year on matters pertinent to the examinations.

Following the last annual meeting of the State Society the Council appointed the Examining Board as a special committee to revise the medical practice act. This committee feels that the act should be reviewed and perhaps revised but the committee temporarily postponed action because of the submission of a bill by the reorganization committee governing the examining board. This committee feels that until this bill has been disposed of it would be unwise to do anything about the revision of the medical practice act.

The question of foreign graduates has been a great problem for the examining board during the past year. Due to changing conditions in Europe it is very difficult for the board to properly evaluate foreign medical schools. Included in this question is that of the refugee. The board is trying to handle this situation fairly and impartially.

Respectfully submitted,  
T. P. MURDOCK,  
Secretary.

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#### REPORT OF EDITORIAL BOARD OF THE JOURNAL FOR THE YEAR 1938-1939

During the year the Editorial Board of five has been augmented by news editors from each of the eight counties whose chief duty it has been to supply anything of interest. To increase the efficiency of the Board the news editors have been invited to attend the regular quarterly meetings. Their assistance has been invaluable in increasing the appeal of the Journal to more of the Society members. At the quarterly meetings routine business has been transacted. Two of the meetings have been held in Hartford, one in Farmington and one in New Haven. In October the Journal moved into its own office at 54 Church St., Hartford, with a full time stenographer of experience in charge.

The Board has endeavored to improve the Journal from month to month. Criticisms are bound to be made and are welcomed as an aid in guiding the policies of the Board. We are not unmindful that a few members have expressed a desire to be exempt from the list of subscribers and also from a pro-rated portion of the annual dues. If there is nothing between the covers of the Journal which is of interest to this number they should not forget the original object for which the Journal was established, namely, to bring together in closer union the medical profession of our State. With this purpose in view our Board has planned and worked for two years.

Each month the financial success of the Journal seems more assured. The advertising for 1939 increased over 30% above that for 1938. We were able to secure as new advertisers, through the assistance of the Cooperative Medical Advertising Bureau of the A.M.A., several large nationally known firms. In one instance ours was the only State Medical Journal added, in other instances we were one of a very few added, and in each case it was not because of our circulation, which is relatively small, but because of the appearance and readability of our publication.

The Connecticut Hospital Association has made official request of our Society that it be allowed to use the Journal as its official publication. The Council has prepared a recommendation to care for this request.

The Board covets your constructive criticism and loyal support.

Respectfully submitted,  
STANLEY B. WELD,  
Editor.

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#### REPORT OF THE COMMITTEE ON THE CLINICAL CONGRESS FOR THE YEAR 1938-1939

The Fourteenth Clinical Congress of The Connecticut State Medical Society was held at New Haven on September 20, 21, and 22, 1938. An excellent program including several new features, had been arranged. In spite of storms and floods all plans were working out well until the afternoon of September 21, when the hurricane struck Connecticut. Although the attendance was diminished nearly all the sessions were completed.

In preparing for the Congress the Committee followed its usual methods and procedures. Through meetings of sub-committees and by consultation with representatives of the county medical associations the interests of physicians throughout the State were ascertained. The program was then constructed on the basis of suggestions received from these and other sources. It was designed

to serve practical needs and to offer general information. The aim was, as in the past, to advance postgraduate medical education through this type of voluntary effort on the part of physicians in holding a yearly educational meeting for which The Connecticut State Medical Society has received widespread commendation.

Yale University and the New Haven Hospital were again pleased to put all the necessary facilities at the disposal of the Congress. Large assemblies were held in the auditorium of the Law School and the afternoon sessions were held in the buildings of the School of Medicine and New Haven Hospital.

The program included nine addresses by authorities invited to speak at the Congress. These were delivered at the morning sessions. The new features of the afternoon sessions were: (1) a series of five-minute talks on a variety of subjects, at the morning sessions; (2) further development of symposia and panel discussions of topics presented in the addresses at the morning sessions; (3) five three-day courses. The subjects of these courses were: contraceptive methods; methods of treatment of fractures; nervous system changes in anoxemia and avitaminoses; recognition of premalignant and malignant lesions; and diagnostic radiology. An additional fee of \$1.00 per person was charged for each course. All the courses were satisfactory, but the one dealing with cancer diagnosis was not completed. The interest aroused by the course in neuropathology was so great that this course has been continued during the months following the Congress, with upwards of forty physicians in attendance.

The total registration was 598, of which number 545 were paid for at \$2.00 each, and 53 were free admissions given to students and internes. The total number was 96 less than last year. It is believed that the storms and hurricane caused this reduction in attendance.

Physicians from Connecticut attending the Congress numbered 529, making up 88.5 percent of the total registration. Of these physicians 397 were members of The Connecticut State Medical Society, who thus composed 66.4 percent of all registrants. The following are some of the comparative analysis of registration at the Clinical Congresses:

Clinical Congress	Year	Number of Registrants	Number of active practicing physicians registered in Connecticut	Percentage of active physicians attending the Congress
11th	1935	627	1980	28.3
12th	1936	633	2057	27.4
13th	1937	694	2202	27.7
14th	1938	598	2209	23.9

It is seen from the above that the Congress attracts slightly less than 30 percent of the actively practicing physicians of the State. It is hoped that the number in this group will increase.

The record of attendance at the 14th Clinical Congress according to counties, in comparison with the total registration, was as follows, as prepared by Dr. Strauss:

	Number	Percentage of Registrants	Percentage of membership in respective Societies
Total registration	598		
From Connecticut	529	88.5	23.6
From Fairfield County	79	13.2	16.7
From Hartford County	105	17.6	17.4
From Litchfield County	15	2.5	18.3
From Middlesex County	24	4.0	29.4
From New Haven County	267	44.7	36.6
From New London County	27	4.5	18.5
From Tolland County	3	0.5	12.0
From Windham County	9	1.5	23.1
From outside of State	69	11.5	
From California	1	0.15	
From Florida	3	0.5	
From Maine	3	0.5	
From Massachusetts	32	5.4	
From Mississippi	1	0.15	
From New Hampshire	1	0.15	
From New Jersey	1	0.15	
From New York	13	2.2	
From Rhode Island	11	1.8	
From Vermont	2	0.35	
From Turkey	1	0.15	

One half of the number of physicians who attended the Congress in 1937 returned in 1938. At the Congress in 1938 there were 144 new registrants, making up 24.1 percent of the total registration.

The report of the Treasurer, Dr. Sanford, is as follows:

Receipts:			
From registration fees	.	.	\$1,228.00
Interest on deposits in bank	.	.	75.38
Total receipts	.	.	\$1,303.38
Disbursements:			
Printing	.	.	\$ 378.61
Clerical work	.	.	196.13
Dinners (Committee)	.	.	67.68
Speakers' expenses	.	.	264.53
Miscellaneous	.	.	190.43
Total disbursements	.	.	\$1,097.38

From this it is seen that the total disbursements were \$130.62 less than the amount collected this year and \$206.00 less than the total income. This surplus was made possible by savings in all items of expense. The luncheons, a recurrent cause of financial loss, were omitted.

The total assets of the Congress in the form of bank deposits amounted to \$3,588.44 on December 31, 1938.



The Journal of The Connecticut State Medical Society was extremely helpful to the Congress. The Journal gave much space to announcements, details of programs and editorial comments. It carried the first requests for registrations. The Committee thanks the editor, Dr. Weld, for his generous and valuable cooperation.

To the Administrative Secretary of the State Society, Dr. Barker, himself a member of the Committee on the Clinical Congress, we owe thanks for sound advice and helpful service. The facilities of his office are at all times at the disposal of the Committee and most of the business of the Congress was conducted through that office.

Shortly after the close of the Congress in 1938 the Committee met to make plans for the Fifteenth Clinical Congress to be held at New Haven on September 19, 20, and 21, 1939. These plans are now well developed and the program is almost complete.

The Clinical Congress is a thoroughly cooperative effort. Services are given to it by a large number of physicians, many of whom put in a great deal of hard work both before the Congress meets and also during its sessions. The Committee is grateful to them. The Chairman wishes to express his personal thanks to all who have contributed their services so loyally and generously, and offers The House of Delegates an expression of his appreciation for the privilege of being one of the agents of The Connecticut State Medical Society in this phase of the Society's program for medical education.

Respectfully submitted,

S. BAYNE-JONES,

Chairman.



#### ANNUAL REPORT OF THE STATE TUMOR COMMITTEE FOR THE YEAR 1938-1939

The duties and activities of this Committee have been increasing from year to year like the proverbial snowball. There have been four regular meetings of the State Tumor Committee during the year 1938-39, and these have been well attended by most of the members, except Dr. Peters who has been ill and has requested that his name be removed from the list of committee members, and our new members, Drs. Verdi and Moore, who have failed to attend any meeting since their appointment.

The work of this Committee consists mainly of the instigation of new projects and the supervision and ratification of the activities of the various committees that constitute this tumor organization.

The three main committees, the Scientific, Publicity and Central Hospital Committee have been active during the year except for the Scientific Committee under the chairmanship of Dr. Weise, who unfortunately misunderstood his assignment.

The Publicity Committee, under the chairmanship of Dr. Ottenheimer, has functioned admirably in continuing the cancer educational work amongst the laity by acting in cooperation with the Cancer Division of the State Department of Health. This Committee consists of the following members: Dr. E. J. Ottenheimer, chairman, Dr. Stanley Osborn, Dr. Carl Johnson, Dr. W. W. Dinsmore, Mr. Herbert Hirsche, Drs. Larkin and McLellan, ex-officio. It has been the opinion of the committee

for some time that perhaps greater activity should be shown by the State Department in the matter of stimulating groups for discussion of the early recognition of cancer, and also to organize data in the central office in Hartford to be available for speakers throughout the State. A definite start has been made in that direction, and the State Department has compiled a very excellent talk in outline form which they will be glad to send to any doctor who is invited to speak before a group on cancer. In addition, a beginning has been made in collecting a photographic library of colored slides showing cancer statistical data, as well as early superficial lesions. This has been done with the cooperation of the Photographic Department of the Hartford Hospital, and it is planned in the future to increase the size of this library so that eventually we shall have on hand a considerable amount of material, both statistical and clinical, as well as clinico-pathological. Again a movement has been started to interest the various groups throughout the State in securing speakers and it has been felt by the committee that these speakers should be more or less selected through the Publicity Committee. In addition, this committee has continued to publish articles in various newspapers throughout the State on the early treatment of cancer and also several excellent radio talks have been given on this subject. Mr. Hirsche reports that there has been an average of eight requests a month for speakers to talk on cancer at various public meetings.

The Central Hospital Committee, appointed in February, 1938, has completed its work under the chairmanship of Dr. Charles L. Larkin with the aid of three sub-committees, the Executive Committee, Dr. P. G. McLellan, chairman, Professor Ira V. Hiscock, Mr. Herbert Hirsche, Dr. William Verdi, Dr. Charles L. Larkin, ex-officio; the Fact Finding Committee, Mr. Herbert F. Hirsche, chairman, Professor Ira V. Hiscock, Dr. John Watkins, Dr. Wilmar M. Allen, Dr. Christopher McCormack; and the Policy and Organization Committee, Dr. Stanhope Bayne-Jones, chairman, Mrs. Doris McBee, Dr. Stanley H. Osborn, Dr. Ralph E. Kendall, Dr. Joseph Howard. The reports of these committees are as follows:

The activities of the Executive Committee, in studying the cancer needs of the State of Connecticut, had several meetings during the year, and several in conjunction with the parent general committee. Their conclusions were briefly expressed in the bill presented before the State Legislature. (See below).

It was the opinion of the Fact Finding Committee that a detailed survey of general and private hospitals and convalescent homes and almshouses should be undertaken to determine the facilities available for cancer patients, particularly those of an indigent character. With this purpose in mind, the committee compiled the necessary basic data and eventually prepared a monograph on its findings entitled "A Report on Facilities Available for the Care of Persons Suffering from Cancer in Connecticut with Special Reference to Indigency." The sum of \$200.00 was appropriated by the State Medical Society and utilized to engage the services of Miss Grace Mooney, Ph. D., as field assistant.

Certain data derived from the findings, based primarily on a study of 2,722 cases of malignant disease, were

as follows: (1) the average stay of all cancer cases in hospitals was 24.8 days, with indigent patients staying on the average of nine days longer than pay patients. (2) The total indigent load was computed as 19.2 per cent of the total cases admitted. An additional 34 per cent were considered as "medically indigent." (3) The total number of beds in constant use by cancer patients in general hospitals was computed as 168.

The committee's conclusions were as follows: (1) A need exists for between 125 and 150 additional beds for chronic terminal cancer patients due to the inability of general hospitals to take care of such cases. (2) Facilities for the care of invalided cancer patients requiring prolonged hospitalization were considered inadequate. Specifically, chronic and convalescent homes and almshouses are not equipped to prolong scientifically or maintain life in comparative comfort. Invalided indigent patients for want of financial support may exist under most unfavorable environmental conditions. (3) The state lacks facilities to take care of incurable indigent cancer patients and, as a result, they are often placed in institutions outside of Connecticut. Thus a pressing need exists for a more satisfactory solution of the problem of institutional care for invalided patients suffering from cancer in its terminal stages. (A copy of the detailed report of this committee is appended.)

The Committee on Policy and Organization held its first and only separate meeting at Hartford on March 22, 1938. At this meeting, a number of questions relating to the cancer situation in Connecticut in general and to the desirability of a central cancer hospital in particular were discussed. The consensus of opinion appeared to be in favor of further development of tumor clinics in general hospitals throughout the State. The Committee was not inclined to favor the attempt to secure a State appropriation for a general cancer hospital. These questions were again discussed at a meeting of the Central Hospital Committee in April 1938. It became apparent that this Committee could not take any more definite actions until it had information from the Fact Finding Committee, the first section of whose report became available to the Committee in December 1938 and after careful study the Policy and Organization Committee reported that they were in favor of State subsidies for the further development of tumor clinics rather than for a central hospital. It was then decided by the parent committee to turn over the proposals to the Executive Committee with power to undertake to present the matter to the State Medical Society and to bring it to the attention of the Legislature.

As the functions of the Central Hospital Committee have been completed for the present, I recommend that its activities be discontinued until such time as the State Tumor Committee again requires its services. The sum of the activities of this Committee may be boiled down to the draft of the two bills that have been presented to the General Assembly of the State of Connecticut for their consideration. A preliminary hearing of these bills was held at the State Capitol on March 14, 1939 before the Committee on Public Health and Safety. It is not known at this time whether or not this Committee passed favorably upon them. The bills presented are as follows:

*Section 1.* There shall be appropriated a sum of \$250,000

for each fiscal year to the State Department of Health, which shall be expended by said department for the hospitalization and treatment of those chronic indigent cancer cases who require prolonged hospitalization. All such hospitalization and treatment shall be in Connecticut hospitals approved by the State Department of Health. Funds provided for in this Act may also be expended among the various tumor clinics in hospitals approved under this Act for increasing their facilities for the prevention of cancer and for the diagnosis and treatment of those residents of the State who may be suffering from cancer. Said appropriation shall be expended in accordance with the rules and regulations of the State Department of Health.

*Section 2.* The State Department of Health is authorized to utilize such proportion of the appropriation made in Section 1 of this Act as may be required for defraying administrative expenses involved in carrying out the provisions of the Act.

The second bill presented was to the effect that cancer be made a reportable disease in the State of Connecticut.

The Association of Connecticut Tumor Clinics continues to function as energetically as formerly. The annual meeting was held on September 21, 1938. The chairmen of the four subcommittees were appointed, and their committee members and reports are as follows:

*Pathology Committee,* Dr. J. O. Collins, chairman, Dr. Louis P. Hastings, Dr. Ralph E. Kendall, Dr. H. M. Zimmermann, Dr. Milton C. Winternitz, ex-officio. The Committee has continued to sponsor a program of monthly informal meetings of the pathologists of the state, most of the meetings having been held at New Haven Hospital through the courtesy of Dr. Winternitz and his associates. Dr. Rosahn at New Britain Hospital and Dr. Larrimore at Greenwich Hospital each served as host to the group at one of its meetings in their respective laboratories.

A system of classification of tumors, based on Logeys Standard Nomenclature of disease, was worked out last year by a sub-committee consisting of Drs. Kendall and Tennant and was this year revised by them and adopted by all the pathologists in the State serving tumor clinics. This system embraces a method of coding tumors, readily adaptable to the sifting of data on the punch machine.

Largely through the efforts of Drs. Kendall and Hastings, a circulating slide library has this year been put into operation. After completing the circuit, the slides thus used with pertinent clinical data are to be catalogued and filed away and it is hoped that they will form the nucleus of a central tumor registry in the state. In this connection, the committee still feels that it is highly desirable that funds be made available for the establishment of such a registry, with a competent personnel, to serve as a sort of clearing house for all tumor diagnoses in the State. It seems improbable that uniformity of nomenclature and grading will be attained otherwise.

*Record Committee:* Dr. Christopher J. McCormack, chairman, Dr. Matthew Griswold, Dr. A. W. Oughterson, Dr. Paul D. Rosahn, Mr. Herbert Hirsche. During the past year, no definite scheduled meetings of this committee were held. Usually, at the meetings throughout the State of the Association of Tumor Clinics, the members of the Committee met and discussed informally the various



problems relating to the records. In a general way, the policies that had been so admirably established by the preceding Record Committees, were carried out.

The various Tumor Clinics have continued to use the forms supplied them by the State Department of Health, and the Record Committee did not feel that any alterations of these forms were advisable at the present time.

The process of setting up a code system for the tabulation of the tumors has progressed during the past year so that in a short time the installation of the system will be accomplished.

*Therapy Committee:* Dr. E. J. Ottenheimer, chairman, Dr. E. H. Kirschbaum, Dr. Louis P. Hastings, Dr. Ralph Ogden, Dr. John Raymer. A definite plan was formulated by this Committee to publish a handbook on cancer, similar to that done by California, Massachusetts and Iowa, and at a meeting of this Committee a group of chairmen were selected to head committees which would deal with various sections of this handbook. Approximately 17 committees were thus organized, and letters were sent to each chairman, giving him the gist of what the committee required, both in formulating his committee and the type of material we wanted. The response to these requests was excellent and at the present time we have at hand a great deal of material, sufficient to begin the editing of the book.

These committees represented all the tumor clinics of the State and the Therapy Committee wishes to express its appreciation for the great amount of effort and time which was devoted by these committees in compiling these various articles. It is hoped that the State Medical Journal will publish these articles individually before they are incorporated into the handbook.

*Program Committee:* Dr. A. W. Oughterson, chairman, Dr. Carl H. Wies, Dr. Kenneth K. Kinney, Dr. Ralph T. Ogden, Dr. Ellwood C. Weise, Dr. Edward W. Foster, Dr. Paul D. Rosahn, Drs. Larkin and McLellan, ex-officio. This committee arranged four unusually fine meetings which were held during the year.

The first was held in Willimantic, at the Windham Community Memorial Hospital on December 8, 1938 under the chairmanship of Dr. Kenneth K. Kinney. The program was as follows:

Introductory Remarks — Dr. K. K. Kinney  
Survey of the Cancer Situation in this Community for the Past Ten Years — Dr. E. J. Ottenheimer  
Analysis of Breast Cancer in the Windham Community Memorial Hospital in the Past Ten Years — Dr. Richard Shea  
Analysis of the Delay in Cancer in this Area — Dr. Brae Rafferty  
Analysis of the Economic Phase of the Cancer Situation in our Area — Mr. W. B. Sweeney  
Discussion — Mr. Herbert F. Hirsche  
Discussion — Dr. Philip G. McLellan

The second meeting was held in the Hartford Hospital on January 27, 1939 under the chairmanship of Dr. Ralph E. Kendall. The program was as follows:  
Observations on the Pathology of Cancer of the Lip and Mouth — Dr. Ralph E. Kendall

Analysis of Cases of Cancer of the Lip — Dr. Welles Standish

Experience with Cancer of the Buccal Cavity at Hartford Hospital — Dr. Douglas J. Roberts

The third meeting was held at New Haven Hospital on March 10, 1939 under the chairmanship of Dr. Clyde L. Deming. The program was as follows:

Report on Cancer of the Prostate — Dr. Charles Y. Bidgood, Dr. Chris H. Neuswanger, Dr. Allen M. Margold, Dr. E. J. Ottenheimer

Incidence and Symptoms of Cancer of the Prostate in 209 Cases — Dr. Dwight Wilson

Diagnosis and Treatment in 209 Cases of Cancer of the Prostate — Dr. W. Rodgers Foote

Pathological Reports on Cancer of the Prostate — Dr. A. A. Liebow

Incidence of Cancer of the Prostate in the State of Connecticut — Dr. John H. Watkins

How Cancer of the Prostate Grows — Dr. W. Edwin Lawrence

The Early Diagnosis of Cancer of the Prostate — Dr. Ralph H. Jenkins

Diagnosis and Treatment with X-Ray of Cancer of the Prostate — Dr. Hugh Wilson

Surgical Treatment of Cancer of the Prostate — Dr. Clyde L. Deming

The fourth meeting was held at New Britain General Hospital on April 13, 1939 under the chairmanship of Dr. Paul D. Rosahn. The program was as follows:

A Survey of Neoplastic Diseases at the New Britain General Hospital 1929-1938

Malignancies of the Gastro-intestinal System — Dr. Geo. W. Dunn

Malignancies of the Breast — Dr. William F. Flanagan

Malignancies of the Female Generative Tract — Dr. Donald A. Bristoll

Malignancies of the Urological System — Dr. Richard W. Pullen

General Survey and Summary of Experience — Dr. Paul D. Rosahn

The Program Committee also plans to put on an instructive series of talks and exhibits at the next meeting of the Clinical Congress.

The Tumor Committee appointed a sub-committee in February 1939 called the Radium Loaning Committee consisting of the following members: Dr. Philip G. McLellan, chairman, Dr. Christopher J. McCormack, Dr. Ralph Ogden, Dr. A. W. Oughterson, Dr. B. M. Parmelee, Dr. C. L. Larkin, ex-officio. The duties of this committee, are to work in cooperation with the Cancer Division of the State Department of Health and draw up rules and regulations as a guide to the National Cancer Institute, so that radium may be loaned to the various institutions in this State in such a manner as to do the most good to the greatest number of patients suffering from cancer. A preliminary report from this committee is as follows: There has been one meeting of the Radium Loaning Committee in addition to several conferences between the chairman and Dr. Knowlton of the Department of Health. It appears that no radium has been dispensed to date and Connecticut has forwarded applications from nine hospitals asking for varying amounts of radium. At

present the Committee is attempting to formulate policies to cooperate with the National Cancer Institute in the hope that some radium will eventually be made available for Connecticut clinics.

Respectfully submitted,  
CHAS. L. LARKIN,  
Chairman.



## REPORT OF THE PUBLIC HEALTH COMMITTEE FOR THE YEAR 1938-1939

In the past year three meetings of the Public Health Committee have been held. During that time a number of problems have been presented, many of which have had definite action taken upon them and others are still in the process of investigation.

### The Question of Obstetrical Consultants

In an effort to improve the standards of Obstetrics in the State of Connecticut, we have endeavored, with the aid of federal funds, to designate a list of men especially trained in Obstetrics who could be called upon as consultants in difficult obstetrical cases. According to the requirements, as specified by the federal authorities, these consultants must be diplomates of the American Board of Obstetrics and Gynecology. Since there were so few of these men in the State of Connecticut and most of these residing in the larger cities where this plan is not included, we were handicapped in the selection of consultants for rural communities where it is needed most.

Several plans have been advocated to include in this list men who have a large obstetrical practice but do not specialize. The names of several men have been submitted to the Committee by the staffs of various hospitals and unfortunately in many instances it was necessary to reject these applicants because they were not members of the County or State Societies. In the rural communities a questionnaire was sent to the various physicians asking them to specify the men whom they might call in as consultants in obstetrics and that data is now being collected. We hope in this way to publish a list of consultants that will cover the state rather thoroughly.

We have also attempted to stimulate the use of this consulting service, but the response has been most disappointing in spite of announcements at the County meetings and monthly notices in the Journal and very few men have taken advantage of this consulting service. In an attempt to increase the use of obstetrical consultants the population of cities eligible for this service was increased from thirty to fifty thousand. It is hoped that in the future the members of the Society may see the object of further reducing our maternal and fetal mortality.

### Post-graduate Education in Obstetrics, Orthopedics and Pediatrics

Efforts have also been made to offer post-graduate education in Obstetrics, Orthopedics and Pediatrics. Refresher courses given in a few hospitals throughout the state were poorly attended and after a year's trial this type of course was discontinued. It was then thought to submit to the various County Societies a list of subjects and speakers in the hope that they might be called upon to speak before these County Societies. There has been very little response from this service. The most promising

post-graduate course was instituted at Yale Medical School during the winter when Doctors Morse and Thoms presented a series of lectures and demonstrations on Obstetrics. These were fairly well attended and gave encouragement to those men in charge to repeat these refresher courses at frequent intervals.

### Compulsory Wasserman during Pregnancy

The Committee during the year, has favored a plan to make Wasserman's compulsory during pregnancy. A bill so drawn was presented to the legislature during the present session and it is hoped that it will meet with a favorable reaction.

### Giving Formulae and Prescriptions at Well-baby Conferences

A problem which has confronted us for the past few years was that of giving formulae and prescriptions at well-baby conferences. There are instances in which this seems necessary, especially in rural towns where there are no local physicians or where the patient is too poor to pay a physician. In these communities where there is no Welfare Department to handle the problem it was felt that this might be conducted through the Public Health Committee with Doctor Clifford of the State Department of Health overseeing this work and reporting any abuses to the Committee.

### Registration of Births

There has been reported by the State Commissioner of Health that many physicians throughout the state are lax in reporting birth certificates. Although attempts have previously been made by sending out letters from the office of the State Society and advising these men of the necessity of registering births early, nevertheless, the abuse still continues. This Committee was very firm in its desire to uphold the law as it now stands and gave its support to the Commissioner where prosecution is necessary for a violation of the law.

### Health Examinations for Domestic, Teachers, etc.

This Committee feels that a plan presented by the American Pediatric Society advocating physical examination of all persons in close contact with children should be sponsored in this state. The number of domestics in close contact with children that were found to be suffering from tuberculosis and syphilis warrants some action on this subject. Rather recent discovery of a school teacher in Bridgeport with an active tuberculosis has also brought this thing before the public. The problem that is presented to the Committee, however, is not simple. Legislation for the correction of the affair meets opposition from labor groups who call it class legislation. Antagonism in Bridgeport by the school teachers because the Board of Education advocated compulsory examination of all school teachers has also slowed up this program. The Committee feels instead of legislative action in this matter it should be an educational campaign in which domestics shall be instructed, as well as those conducting employment agencies, whereby girls holding certificates of good health will be in greater demand and can command a better wage.

### Maternal Deaths

A few years ago the State Society instituted a Maternal Mortality study, but this was discontinued after a year or two. This Committee feels that this study should be



again revised and with the cooperation of the State Health Department questionnaires are now being sent to physicians throughout the state in all cases of maternal deaths, so we may study more thoroughly the causes and reduce our mortality, if possible.

#### **Routine Use of Scarlet Fever Streptococcus Toxin**

A resolution was received from the Hezekiah Beardsley Pediatric Club of the State Society relating to the routine use of scarlet fever streptococcus toxin for immunization for children found susceptible by the Dick test. It was the opinion of this Committee that the toxin for immunization has not yet been sufficiently removed from the experimental stage to recommend the routine use and, therefore, they expressed their disapproval of its general use, except in special situations such as contagious hospitals for nurses and other personnel.

#### **Milk, Food and Drug Inspection**

The question of milk, food and drug inspection was discussed by this Committee and it was the unanimous opinion that these departments should be under the State Department of Health and the Committee therefore goes on record as approving the plan to place these departments under the State Department of Health.

#### **Health Program for School Children**

Doctor Osborn felt that there were not enough school physicians at the present time to examine all children and he therefore suggested that the State Board of Education might furnish blanks for physicians to fill out, the parents taking their children to their family physician and presenting these blanks when the child was admitted to school and only the poor children being examined by the school doctors. This matter is still under discussion by the Pediatric section of this Committee and some plan will be presented within a short time.

#### **First-aid Education**

Doctor Yergason of the Orthopedic section of this Committee prepared and presented a very comprehensive program for first-aid education of truck drivers, ambulance drivers and all other persons who might at times be called upon in an emergency. He also presented with this a program for a first-aid convention to be held in an armory or similar large institution, for the demonstration of all appliances used in first-aid work. This plan was endorsed by this Committee and referred to the Council which acted upon it favorably. The convention is of such proportions that it may require two years to work out the details. However, it seems that it will be a very worthwhile undertaking.

#### **The Film "The Birth of a Baby"**

Considerable pressure has been brought to bear on members of the Committee and members of the State Society for the approval of the showing of the film, "The

Birth of a Baby", in theatres throughout the state. It is the feeling of the Committee and those contacted outside the Committee that this film is not suitable for public showing.

#### **Requirements for Licensing Maternity Hospitals**

Several complaints have come to the attention of the Committee that smaller maternity hospitals were not occupied by patients, but were rented out to transients. This Committee, therefore, went on record as condemning this practice and insisting that the requirements for licensing maternity hospitals should be lived up to by the smaller hospitals.

#### **Pre-natal Clinics**

The necessity for more pre-natal clinics throughout the state was discussed at some length, but the problem has not been definitely settled and further discussion will be continued.

The members of the Committee have been most enthusiastic in their cooperation and I wish to extend to these Committee members my appreciation of their efforts. Whatever success has been accomplished by this Committee during the past year has been due in a large part to the suggestions and activities of the State Department of Health through Doctor Osborn and Doctor Clifford, to whom I express my thanks.

Respectfully submitted,

JOSEPH H. HOWARD, M.D.

Chairman.

(To be continued)



#### **FRESH BLOOD SHOULD BE USED FOR HEMORRHAGE DUE TO JAUNDICE**

Only freshly drawn blood should be used for transfusions to combat the tendency to hemorrhage in jaundice, Jonathan E. Rhoads, M.D., and Lillian M. Panzer, Philadelphia, state in *The Journal of the American Medical Association* for Jan. 28.

In their comparative study of "bank blood" and fresh blood they found that the prothrombin content (anti-hemorrhagic factor) of "bank blood" was greatly reduced. Blood that has been in the "bank" a week or more is practically useless in the treatment of the hemorrhagic tendency in jaundiced patients, unless of course, they are also treated adequately with vitamin K and bile salts.

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(SEE PAGE 2.)

## • OBITUARIES •

### RALPH AUGUSTINE McDONNELL, M.D., 1868-1939

Ralph Augustine McDonnell was born August 20, 1868, in Topsham, Maine, the son of Captain John A. McDonnell, U.S.A. and Valeria B. Dennett. On his father's side he came of that physically and mentally tough old stock commonly described as Scotch-Irish; on his mother's side he was of Maine Yankee stock. He received his primary education in the public schools of Topsham and his secondary schooling at the Academy in Newburgh, New York, from which he graduated in 1886. The following fall he entered Yale College and received his A. B. with the class of 1890. At that time graduates of Yale College received a credit of one year in the Yale Medical School, which then had a three-year course, so that Ralph McDonnell graduated in medicine in 1892, winning the Campbell Gold Medal for the highest marks in the examinations of the course. After graduation McDonnell went to Europe for a year, which he spent in study in Paris, Vienna and Berlin. In 1893 he returned to New Haven and began the practice of medicine, which he continued up to within a few weeks of his death. He showed his interest in dermatology early in his career and from 1893 to 1897 was assistant in Dermatology and from 1897 to 1902 Instructor in Dermatology in his Alma Mater. In 1902 he was appointed Clinical Professor of Dermatology, which position he held until 1920 when he retired and was placed on the emeritus list.

Very soon after the discovery of x-rays Dr. McDonnell became interested in their use in dermatology and at a time when the dangers of radiation were not appreciated he constantly exposed himself without adequate protection. As a result of this he acquired x-ray lesions of his hands which subsequently underwent malignant degeneration. Over a period of years he had a series of operations on his hands, and in the summer of 1938 had an operation for the removal of a metastatic x-ray carcinoma from the left axilla. His death May 26th, 1939, was due to a recurrence of the neoplasm.

Dr. McDonnell always took an active interest

in his specialty. He was a member of the American Dermatological Association, to which he was elected in 1913, and he was also a member of the recently formed American Academy of Dermatology and Syphilology, to which he was elected in 1938. He was dermatologist to the New Haven Hospital from 1915 to 1920 and Consulting Dermatologist from 1921 to 1928. During his active period he was also head of the dermatological clinic of the New Haven Dispensary.

Ralph McDonnell was actively interested in the affairs of the City, County and State Medical Associations. He was President of the City Association in 1900, served for a number of years as the Councilor from New Haven County to the State Medical Association, and was elected President of that body in 1933. He took an active part in the affairs of all of these associations and by his practical, hard-headed, common-sense views earned the respect of his colleagues.

He had a very active interest in his college class (1890) and was Class Secretary from 1935 until the time of his death. In this position he showed the same efficiency that he did in anything he undertook and managed to keep his classmates constantly informed of the goings-on of their colleagues. A few days before his death his classmates presented him with a handsome silver bowl, appropriately inscribed.

Dr. McDonnell was married August 4, 1892 to Lillian M. Washburn of New Haven. They had three sons, Dr. Ralph E. McDonnell, Frank, and Charles W. McDonnell, and at the time of his death Dr. McDonnell had five grandchildren.

Ralph McDonnell was a man of strong convictions which he did not hesitate to express fearlessly. He was not one, however, who was unable to see the other side of any subject in which he was interested. He was a conservative rather than a radical and he was always scrupulously fair in his presentation of facts. His intestinal fortitude was well demonstrated in his last illness, of the nature and outcome of which he was perfectly aware. His attitude during this period of suffering and discomfort is well summed up in a verse from Henley's well-known poem "Invictus."

"In the fell clutch of circumstance  
I have not winced nor cried aloud;  
Beneath the bludgeonings of chance  
My head is bloody but unbowed."

William F. Verdi, M.D.

George Blumer, M.D.



## GEORGE MICHAEL FLANAGAN, M.D.

1877-1939

The personal qualities of Dr. George Flanagan made him beloved by his patients and admired and respected by his fellow physicians. He possessed to an admirable degree strength of mind and body with a gentleness of manner and innate courtesy and consideration for all persons. In the course of his twenty-seven years in practice he developed a large and uncommonly devoted group of patients. His practice was principally in general medicine and obstetrics and this made great demands upon his energies, yet he found a way to be unhurried and to be a patient and understanding counselor. His patients remained loyal to him and dependent upon his skill even into the years of his illness and restricted energies.

Among the physicians, Dr. Flanagan was generally liked and respected. He was without pose or pretense but he was firm in his belief and had rich experience and judgment. His large frame and his features, dignified and a little grave, and in later years his wealth of white hair, made him a splendid figure for a physician.

Dr. Flanagan was born in New Britain in 1877. He attended the local schools where he made a name for himself as an athlete. After his graduation from High School he worked for several years as plant superintendent in a local factory and later at Cohoes, N.Y. In 1907 he gave up his employment and entered the College of Physicians and Surgeons in Boston. After this he served an internship at St. Francis Hospital in Hartford. For many years he was a member of the medical visiting staff at the New Britain General Hospital. He was a member of the American Medical Association, the Hartford County Medical Association and the New Britain Medical Society.

During the several years of his imperfect health, Dr. Flanagan was reluctant to refuse the demands of his patients and he continued a limited practice until shortly before his death. In the last two weeks of his life his courage and spirit remained keen and an inspiration to all.

John C. White, M.D.

## • Quarto Notes •

## PRECLINICAL MEDICINE

by

Malford W. Thewlis, M.D.

223 pages

\$3.00

Baltimore The Williams and Wilkins Co. 1939

Dr. Thewlis, a physician of wide experience in general medicine and public health, has given, through the medium of this book, numerous clues which will aid the physician in detecting *tendencies* to disease. The chapters are well written, very readable, and contain practical gems from the author's private memoirs which are made available to the general physician. They are systematically grouped under the following sections:

1. General Considerations
2. Specific Infectious Diseases
3. Non-Infectious Diseases
4. Pathologic Possibilities

The twenty-three chapters in all are well arranged and truly depict the author's effort to give to the profession the factual data on preclinical conditions as obtained from his years of experience and from the sources enumerated in the excellent fifteen pages of Bibliography.

Of especial interest are the chapters on "Constitution" which summarize the important points on heredity and types; on "Allergy;" "The Heart and Blood Vessels;" "The Respiratory Tract;" "The Alimentary Tract;" "Metabolism;" and "Cancer."

The title "Preclinical Medicine" truly expresses the subject matter. In reality, it is an up to date resume' of preventive medicine. A truly enjoyable book of interest and value to all medical men.

O. L. Stringfield

—☆☆—

ORGANIZED PAYMENTS FOR  
MEDICAL SERVICES.

by

By the Bureau of Medical Economics, American  
Medical Association. Paper. Pp. 185

Chicago: American Medical Association. 1939

It would stretch the imagination of a social planner to devise any scheme for the organized payment for medical services that is not described in this publication of the Bureau of Medical Economics of the American Medical Association on "Organized Payments for Medical Services." Several hundred plans for medical care of the indigent involving governmental support and medical society management are explained. Social Security legislation has brought about changes in medical arrangements reaching into almost every locality in the United States and affecting health departments, medical societies, and state and local governments. Types of plans proposed by the Farm Security Administration to provide medical services to Administration clients in 127 counties and

covering 100,000 low income families are described. Medical societies have organized postpayment and prepayment plans of medical care offering a wide selection of types. Some provide for a cash indemnity to be paid to the insured with which he can purchase his own medical service and others provide medical service directly.

Industries, unions, fraternal organizations, and all sorts of mutual societies provide medical benefits for their members by a variety of prepayment devices. Some 3,000,000 persons are covered by group hospitalization plans, which show a wide variety of relations with state and county medical societies. Commercial insurance companies, all of whom pay benefits in cash, are also entering this field on a large scale. It is estimated that approximately \$300,000,000 in cash is paid out annually by insurance companies to assist in paying medical bills.

The House of Delegates of the American Medical Association has endorsed cash indemnity prepayment plans, but has not sought to prohibit any of its component societies from cooperating with or organizing other types of prepayment for medical service provided their character is not such as to render it impossible to give good medical service.

The number and variety of the plans for medical services — operating and proposed, postpayment and prepayment, service and cash, medical society and other organization sponsored — give proof of the efforts that are being made to supplement the private practice of medicine and indicate a desire to discover, by social experimentation, a solution of local medical problems.



## RURAL MEDICINE

Proceedings of the Conference Held at Cooperstown, New York, October 7 and 8, 1938

268 pp.

\$3.50

Springfield, Ill.,

Chas. C. Thomas. 1939

At this time when provisions for adequate medical care are particularly under fire the material from the conference at Cooperstown last October is of unusual interest. Represented among the speakers at the conference was the local hospital, the local County Medical Society, Johns Hopkins University School of Hygiene and Public Health, College of Physicians and Surgeons of Columbia University, University of Michigan, Vanderbilt University, Leland Stanford University, General Electric Company, U.S. Public Health Service, Committee on Research in Medical Economics and the American Medical Association.

The Conference dealt with rural morbidity, health department programs and school health programs in rural areas, postgraduate medical education in rural areas and economics of rural medicine.

Many interesting facts are found in this volume. For example, it was emphasized by one of the speakers on rural morbidity that the conference was particularly to be commended because it provided opportunities to approach the problem of rural medicine from many different angles.

This speaker considered the most significant thing to be the fact that the hospital regards itself as an instrument in public health and public health is something in which it must be interested. Means of transportation to rather than the distance from a hospital were shown to be vital factors in medical care in rural areas. The occupation of farming was found to lead all others as a cause of accidents in proportion to the number of persons employed, the mass exposed, as well as in all other factors.

The Conference emphasized the inadequacy of the present system of school health examinations, not the fault of the school physicians, but rather the responsibility of the medical profession and the parents in a given community. One speaker favored having some of the routine work of school health examination done by the family physician.

Experience with postgraduate medical education was found to have varied. Around Vanderbilt University only 10 to 20 per cent of physicians given such opportunities did not avail themselves of them while in Maine where fellowships are being offered for postgraduate study through a special fund not more than 10 per cent of practicing physicians have taken advantage of such study.

Interesting conclusions are drawn by this conference. To quote one of these: "Giving due consideration to the natural limitations of available data, the indication seems clear that many rural communities, a large part of the country and a considerable proportion of the population are now being served by a minimum amount of hospital facilities." Another conclusion, "that rural people get considerably less hospital care than do those in metropolitan areas." It was shown that in relation to their population the 27 states of the Southern and Central regions have considerably fewer hospital facilities and that the people get considerably less hospital care than do similar areas in the other three geographic regions. In a large proportion of rural areas the local community is unable to contribute much towards the financing of hospital construction. Participation by larger communities, often by the State, may be necessary. Federal grants may be necessary in order to equalize somewhat the very great differences in economic resources among the states, not only as regards hospital building but also hospital maintenance.

Michael M. Davis, chairman of the Committee on Research in Medical Economics, expressed himself as believing that we need more rural physicians and more rural hospital beds and that to draw physicians into such rural areas and keep them there will depend upon the cultural opportunities afforded. He does not view with alarm the participation of the federal government with the states in rural hospitalization so long as the methods of administration place the primary responsibility on the states and through them upon the localities.

The conference at Cooperstown was the first of its kind to be held in this country. This volume affords considerable data worthy of careful thought to the student of the great problem of medical care. Factual scientific investigations in this field are few and incomplete. We predict an ever increasing interest in the near future.



# ROSTER of MEMBERS

## 1939

### FAIRFIELD COUNTY

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*Vice President*, BERKELEY M. PARMELEE, 144 Golden Hill St., Bridgeport.

*Secretary*, J. GRADY BOOE, 144 Golden Hill St., Bridgeport.  
*Treasurer*, CLIFTON C. TAYLOR, 881 Lafayette St., Bridgeport.

*Councilor*, JAMES D. GOLD, 839 Myrtle Ave., Bridgeport

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(One elected annually for a term of three years)

1936 ROBERT J. LYNCH, M.D., 144 Golden Hill Street, Bridgeport.

1937 JOHN F. SHEA, M.D., 144 Golden Hill Street, Bridgeport.

1938 JOHN H. STAUB, M.D., 100 South Street, Stamford.  
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 (Appointed annually by the President)

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(Two appointed annually by the President for a term of four years)

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#### *Committee on Medical Economics*

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BERKELEY M. PARMELEE, M.D., 144 Golden Hill Street, Bridgeport.

MORRIS P. PITOCK, M.D., 570 Post Road, Fairfield.

WILLIAM A. SUNDERLAND, M.D., 158 Deer Hill Avenue, Danbury

J. LEONARD VICKERS, M.D., 31 Hillside Drive, Greenwich.  
 Annual Meeting, Second Tuesday in April, at Bridgeport.

Semi-Annual Meeting, First Wednesday in October.

### BETHEL

1925 Moore, Homer Franklin, 4 Grand ave.

1938 Trimpert, Albert J., 155 Greenwood ave.

1939 Wolfson, Dexter, 58 Greenwood ave.

### BRIDGEPORT

1933 Adzima, Joseph Matthew, 409 Noble ave.

1932 Alpert, Max, 881 Lafayette.

1935 Antell, Maxwell Joseph, 1690 Barnum ave.

1920 Apsel, Abraham, 1620 Fairfield ave.

1928 Backer, Marcus, 881 Lafayette.

1938 Bakunim, Maurice Irving, 654 Clinton ave.

1916 Banks, Daniel Tony, 385 Barnum ave.

1913 Beaudry, Joseph Horace, 109 Rowsley.

1913 Bernstein, Abraham, 472 State.

1900 Blank, Elmer Francis, 387 Noble ave.

1935 Bogin, Maxwell, 144 Golden Hill.

1921 Booe, John Grady, 144 Golden Hill.

1927 Brodsky, Michael Emanuel, 881 Lafayette.

1939 Buckhout, George Atherton, 2911 Fairfield ave.

1938 Buckley, John William, 2080 North ave.

1923 Buckmiller, Frank Charles, 1119 Stratford ave.

1919 Calvin, Claudius Virgil, 144 Golden Hill.

1920 Carroll, Francis Patrick, 919 Fairfield ave.

1932 Carroll, Philip Roger, Jr., 1131 Noble ave.

1920 Cheney, Maurice Lionel, 144 Golden Hill.

1925 Cohen, Joseph, 1130 Stratford ave.

1924 Conklin, Cornelius Stephen, 468 Clinton ave.

1936 Connors, Edwin Robert, 416 Boston ave.

1935 Creaturo, Nicholas Edward, 1286 East Main.

1913 Curley, William Henry, 881 Lafayette.

1908 Curran, Philip John, 144 Golden Hill.

1894 Day, Fessenden Lorenzo, 819 Myrtle ave.

1935 Del Vecchio, Leonard Frederick, 763 Noble ave.

1920 DeLuca, Horatio Roger, 881 Lafayette.

1921 De Witt, Edward Nicholas, 881 Lafayette.

1939 Edgar, Katherine J., 590 Brewster.

1937 Eimas, Aaron, 881 Lafayette.

1939 Esposito, Joseph John, 144 Golden Hill.

1913 Finkelstone, Benjamin Brooks, 144 Golden Hill.

1897 Fleck, Harry Willard, 897 Lafayette.

1938 Foley, Francis Xavier, 2992 Main.

1908 Formichella, Giovanni, 534 E. Washington ave.

1916 Gade, Carl Johannes, 144 Golden Hill.

1939 Gaffney, Charles Bernard, 850 Howard ave.

1929 Garbelnick, David Abraham, 1102 E. Main.

1907 Gardner, Charles Wesley, 144 Golden Hill.

1916 Garlick, George Burroughs, 144 Golden Hill.

1916 Gilday, James Lowry, 819 State.

1927 Gildea, Mark Andrew, 881 Lafayette.

- 1895 Gold, James Douglas, 839 Myrtle ave.  
 1927 Greenspun, David Stoven, 144 Golden Hill.  
 1916 Griffin, Daniel Patrick, 1278 E. Main.  
 1923 Griswold, Arthur Sheldon, 144 Golden Hill.  
 1928 Griswold, Crawford, 144 Golden Hill.  
 1920 Groark, Owen James, 881 Lafayette.  
 1913 Hale, Fraray, 144 Golden Hill.  
 1939 Hardenburg, Daniel Bailey, 881 Lafayette.  
 1937 Harper, Paul, 144 Golden Hill.  
 1928 Harshbarger, Isaac Long, 144 Golden Hill.  
 1920 Havey, Leroy Austin, 144 Golden Hill.  
 1938 Hennessey, Joseph Gerard, 108 Rowsley.  
 1915 Hippolitus, Paul DiFrancesca, 255 Barnum ave.  
 1930 Hooper, G. Herbert, 1643 E. Main.  
 1933 Horn, Benjamin, 620 Clinton ave.  
 1916 Horn, Martin Irving, 915 North ave.  
 1920 Howard, Joseph Henry, 144 Golden Hill.  
 1938 Hurlburt, Edward Glens, 610 Laurel ave.  
 1912 Hyde, Charles Elias, 881 Lafayette.  
 1932 James, Arthur Gregory Boswell, 1424 Stratford ave.  
 1932 Kalman, Eugene, 1389 Fairfield ave.  
 1927 Keegan, Daniel Francis, 144 Golden Hill.  
 1938 Kemp, Edward Philip, 881 Lafayette.  
 1938 Keys, Robert C., 881 Lafayette.)  
 1924 Kneale, Halford Benson, 144 Golden Hill.  
 1924 Kornblut, Alfred, 1539 Fairfield ave.  
 1913 Lambert, Henry Bertram, 144 Golden Hill.  
 1926 Laszlo, Andras E., 881 Lafayette.  
 1925 Levenson, Albert, 881 Lafayette.  
 1904 Leverty, Charles Joseph, 528 Park pl.  
 1933 Levinsky, Maurice, 480 Noble ave.  
 1927 Levy, Maurice Noel, 480 Clinton ave.  
 1931 Lockhart, Reuben Harold, 144 Golden Hill.  
 1887 Lynch, John Charles, 826 Myrtle ave.  
 1904 Lynch, Robert Joseph, 144 Golden Hill.  
 1932 Margulis, Abraham Bernard, 171 Harrison.  
 1922 Maxwell, John Alphonsus, 919 Stratford ave.  
 1938 McLean, Thomas Smith, Jr., 1403 Boston ave.  
 1923 McManus, James Patrick, 1390 E. Main.  
 1913 McQueeney, Andrew Michael, 1315 Noble ave.  
 1931 Meyer, Fritz Martin, 144 Golden Hill.  
 1892 Miles, Henry Shillingford, 144 Golden Hill.  
 1932 Mooney, Sydney, 1116 Stratford ave.  
 1936 Murray, William J. C., 784 Noble ave.  
 1938 Nespeco, James V., 2546 Main.  
 1901 Nettleton, Irving LaField, 775 Washington ave.  
 1919 Neumann, Harry Aaron, 588 State.  
 1937 Newton, Louis, 840 Howard ave.  
 1925 Nichols, Charles William, 1221 Stratford ave.  
 1920 Nickum, John Stanley, 144 Golden Hill.  
 1936 Nolan, John Francis, 1260 E. Main.  
 1925 O'Brien, Francis James, 74 Circular ave.  
 1920 O'Connell, John Gabriel, 144 Golden Hill.  
 1921 Parmelee, Berkley Melvin, 144 Golden Hill.  
 1937 Pascal, Thomas J., 385 Noble ave.  
 1920 Pasuth, Bartholomew Charles, 534 Connecticut ave.  
 1909 Patterson, Daniel Cleveland, 881 Lafayette.  
 1913 Peters, Henry LeBaron, 763 Park ave.  
 1930 Pileggi, Peter, 743 Washington ave.  
 1935 Plukas, Joseph Martin, 339 South ave.  
 1933 Quatrano, Joseph Charles, 835 Fairfield ave.  
 1916 Quinn, John Francis, 144 Golden Hill.  
 1916 Reich, Upton Sharett, 2095 Main.  
 1938 Ribner, Harold, 881 Lafayette.  
 1918 Roberts, Edward Russell, 144 Golden Hill.  
 1913 Roche, Thomas Joseph, 1815 Noble ave.  
 1936 Rockwell, Alice Elizabeth, 1775 Noble ave.  
 1913 Rowe, Michael James, 285 Congress.  
 1928 Sekerak, Arthur Joseph, 938 E. Main.  
 1938 Sekerak, Raymond Andrew, 1458 E. Main.  
 1938 Sekerak, Richard John, 1458 E. Main.  
 1938 Shea, Cornelius Joseph, 26 Vine.  
 1913 Shea, John Francis, 144 Golden Hill.  
 1937 Shea, Richard O'Brien, Welfare Building.  
 1903 Smith, Edward Dorland, 881 Lafayette.  
 1939 Smith, Frederick J. C., Boston and Bond ave.,  
 c-o Gen. Elec. Co.  
 1939 Smith, George Yale, 1363 Fairfield ave.  
 1935 Smith, Joseph Jacob, 300 Stratfield rd.  
 1919 Smith, Stanton Reinhart, 144 Golden Hill.  
 1913 Smykowski, Bronislaw Louis, 405 Barnum ave.  
 1930 Sollosy, Alexander, 645 Bostwick ave.  
 1909 Sprague, Charles Harry, 29 Hanover.  
 1920 Taylor, Clifton Clark, 881 Lafayette.  
 1938 Ter Kuile, Roger Couville, 881 Lafayette.  
 1925 Tolk, Nathan Robert, 558 Clinton ave.  
 1895 Tukey, Frank Martin, 144 Golden Hill.  
 1929 Turchik, Frank, 1831 Barnum ave.  
 1934 Tuttle, Alexander James, 2180 Main.  
 1932 Uvitsky, Irving Harry, 3101 Main.  
 1923 Walsh, James Francis, 583 Noble ave.  
 1903 Warner, George Howell, 144 Golden Hill.  
 1920 Watts, Joseph Francis, 881 Lafayette.  
 1913 Weadon, William Lee, 144 Golden Hill.  
 1922 Weise, Ellwood Carl, 144 Golden Hill.  
 1914 Weldon, Edwin Bernard, 144 Golden Hill.  
 1936 Yeager, Charles Frederick, 2139 E. Main.  
 1935 Zaur, Israel Sidney, 881 Lafayette.
- BROOKFIELD CENTER
- 1939 Brewer, Francis.
- DANBURY
- 1929 Amos, Isadore Louis, 317 Main.  
 1929 Booth, John Dibble, 173 Main.  
 1902 Bronson, William Thaddeus, 41 West.  
 1888 Brown, David Chester, 330 Main.  
 1928 Delohery, Cornelius Leo, 65 Main.  
 1935 Driscoll, Jerome James, 206 Main.  
 1937 Eckert, George Robert, 394 Main.  
 1931 Gaffney, John James, 179 Main.  
 1931 Genovese, Frank Thomas, 172 White.  
 1930 Gibson, Donald Farnham, 75 West.  
 1929 Goldys, Frank Max, 209 Main.  
 1897 Gordon, William Francis, 26 West.  
 1912 Moore, Howard Delano, 203 Main.  
 1912 Mullins, Samuel Frederick, 116 Main.  
 1937 Murphy, James Joseph, 147 Main.  
 1937 Rogol, Louis, 229 Main.  
 1926 Selleck, Nathaniel Benedict, 215 Main.  
 1913 Smith, Arthur Charles, 246 Main.  
 1920 Stahl, William Martin, 343 Main.  
 1884 Stratton, Edward Augustus, 112 E. Liberty.  
 1907 Sunderland, Paul Ulysses, 160 Deer Hill ave.  
 1929 Sunderland, William Alexander, 158 Deer Hill ave.  
 1932 Tomaino, Felix Francis, 38 West.



## DARIEN

- 1937 Huntington, Frederic Sargent, Middlesex and Hol-low Tree Ridge Roads.  
1938 VanTassel, Walter, 194 Post rd.

## FAIRFIELD

- 1928 Biehn, Sidney Lister, 22 Reef rd.  
1938 Fulstow, Marjorie, 570 Post rd.  
1932 Pitock, Morris Philip, 570 Post rd.

## SOUTHPORT

- 1938 Mathews, Frank Pelletreau, Main st.

## GREENWICH

- 1935 Amoss, Harold Lindsey, 21 Field Point rd.  
1905 Burke, William, 153 Mason.  
1938 Carter, Gray, 29 Hillside ave.  
1934 Clark, J. Bayard, 290 Field Point rd.  
1904 Clarke, John Alexander, 92 Mason.  
1933 Close, John Frederick, 66 Milbank ave.  
1937 Hawthorne, Julian, Greenwich Towers.  
1937 Craighill, Margaret D., 40 West Elm st.  
1937 Gates, Aaron Billings, 305 Milbank ave.  
1934 Hitchcock, Freeman St. Clair, 275 N. Maple ave.  
1927 Knapp, Charles Stanley, 18 Field Point rd.  
1918 Knapp, Charles Whittlemore, 43 Maple ave.  
1916 Knowlton, Donald Jerome, 36 Mason.  
1933 Lockwood, Jane, 259 E. Putnam ave.  
1932 \*McCreery, John Alexander, 43 Maple ave.  
1939 Reynolds, Whitman Mead, 53 Mason st.  
1935 Rogers, Robert Page, 111 North.  
1938 Serrell, Howard P., 43 Maple ave.  
1937 Stroebel, Joseph E., 34 Benedict pl.  
1937 Thompson, Sidney Attilio, 161 Mason.  
1934 Tinkess, Donald Ewing, Greenwich Towers.  
1933 Vickers, James Leonard, 31 Hillside Drive.

## COS COB

- 1912 Bergin, Thomas Joseph, 2 Mead ave.

## OLD GREENWICH

- 1914 Austin, Albert Elmer, 13 Arcadia rd.  
1926 Kaprielian, Haigazoon Kruger, 312 Sound Beach ave. Also Stamford.  
1936 Kelly, James Colman Francis, 282 Sound Beach ave.  
1939 Read, Francis Arnold, 127 Sound Beach ave.  
Shermak, Joseph V., 13 Arcadia rd.

## MONROE

## STEPNEY DEPOT

- 1912 Wales, Francis Joseph.

## NEW CANAAN

- 1937 Abrahams, Meyer, 191 South.  
1933 Bucciarelli, John Anthony, 93 East ave.  
1939 Cammann, Oswald DeN., 80 South ave.  
1938 DuBois, Franklin Smith, Silver Hill.  
1939 Frothingham, John Gerrish, 149 South Main st.  
1932 \*Lowsley, Oswald Swinney, "Twin Knolls" 29 Cherry  
1939 McElroy, Patrick Thomas, 25 Church st.  
1908 O'Shaughnessy, Edmund Joseph, 29 Cherry.  
1938 Silenger, Jerome, Elm st.  
1935 Terhune, William Barclay, Silver Hill.  
1931 Wadsworth, Ruth Flanigen, Smith Ridge.

## NEWTOWN

- 1938 Dean, Stanley Rochelle, Fairfield State Hospital.  
1927 Desmond, Waldo Fairfield.  
1935 Grout, Stillman Proctor, Fairfield State Hospital.  
1936 Moore, Clifford Douglas, Fairfield State Hospital

- 1938 Smilgin, Victor Edward, Fairfield State Hospital.

## SANDY HOOK

- 1937 Egee, J. Benton.  
1933 George, John Joseph.

## NOROTON HEIGHTS

- 1939 Kaminsky, David, Fitch Home.

## NORWALK

- 1912 Bryon, Benn Adelmer, 344 Main ave.  
1933 Chipman, Sidney Shaw, 520 West ave.  
1938 Gorham, Grace Viola, 64 Wall.  
1915 Kellogg, Henry Kirke White, 725 West ave.  
1930 Miller, John, 711 West ave.  
1938 Northrop, Robert Arthur, 64 Wall.  
1938 Padula, Ralph Domenick, 502 West ave.  
1929 Patterson, Frederic Arthur, 520 West ave.  
1938 Perdue, Robert E., 625 West ave.  
1930 Perkins, Charles Winfield, 520 West ave.  
1920 Perry, Mabelle Jeane, 676 West ave.  
1938 Piasecki, Joseph L., 520 West ave.  
1928 Scanlon, Thomas Francis, 394 West ave.  
1934 Stone, William Stephen, Chestnut Hill.  
1929 Tracey, Edward John, 637 West ave.  
1890 Tracey, William Joseph, 637 West ave.  
1920 Tracey, William Wallace, 637 West ave.  
1904 Turner, Arthur Robert, 701 West ave.  
1938 Vollmer, John William, 654 West ave.  
1934 Wallace, Victor George Henry, 463 West ave.  
1938 Weinstein, Nathan, 463 West ave.

## SOUTH NORWALK

- 1936 Beck, Eugene Cornelius, 75 So. Main.  
1918 Bradley, Theron Robert, 9 Washington.  
1938 Corridon, James Donald, 47 Seaview ave.  
1922 Fawcett, George Gifford, 8 Washington.  
1938 Giuliano, Louis Augustine, 111 West ave.  
1923 McMahon, William Henry, Jr., 13 Washington.  
1938 Hunkemier, Edna, 75 So. Main.  
1938 Paris, Marcus, 64 So. Main.  
1938 Rosenthal, Isidor, 72 So. Main.  
1939 Scanlon, John Joseph, 230 West ave.  
1896 Sherer, Henry Clifford, 1 Washington.  
1931 Simon, Louis Goodwin, 59 South Main.  
1937 Stietzel, Eric Ernest, 19 Franklin.  
1923 Wolfe, Robert Milton, 61 South Main.  
1939 Zweben, Albert, 74 South Main.

## RIDGEFIELD

- 1937 Bell, Joseph Sloane, 54 Main.  
1938 Genovese, Serafino, 104 Main.  
1926 Lowe, Russell Walter, 126 Main.  
1927 Woodford, Francis Bowditch, 62 Main.

## SHELTON

- 1917 Finn, Edward James, 452 Howe ave.  
1930 Gaetz, Thomas Harold, "Laurel Heights."  
1937 Howlett, Kirby Smith, Jr., "Laurel Heights."  
1925 Lynch, Edward James, "Laurel Heights."  
1895 Randall, William Sherman, 241 Coram ave.  
1938 Rilance, Arnold Boor, "Laurel Heights."

## STAMFORD

- 1937 Awdziewicz, Francis J., 295 Atlantic.  
1936 Bannon, Frederick Michael, 65 South.  
1907 Barnes, Frank Haslehurst, Dr. Barnes, Sanitarium.  
1927 Bissell, Addison Hayes, 65 South.

1926 Bowman, Stuart Howard, 58 South.  
 1928 Brown, Paul Hemingway, 52 South.  
 1935 Carpenter, Robert Morse, 636 Sumner.  
 1937 Carwin, Joseph L., 188 W. Main.  
 1904 Cloonan, John Joseph, 37 South.  
 1937 Costanzo, James Joseph, 58 South.  
 1909 Crane, Ralph William, 50 Glenbrook rd.  
 1937 Cunningham, Robert D. M., 123 Prospect.  
 1934 D'Andrea, Frank Henry, 29 South.  
 1909 Dichter, Charles Levi, 33 Forest.  
 1935 Dichter, Irving Samuel, 24 Suburban ave.  
 1937 Di Francesco, Lindo Peter, 29 South.  
 1937 Dorion, Robinson Harry, 449 Atlantic.  
 1933 Fincke, Charles Louis, 1 Atlantic.  
 1937 Fine, Barnet, 49 Grove.  
 1936 Fine, Joseph, 96 Main.  
 1931 Fiske, Madeline, 29 Suburban ave.  
 1934 Friedberg, Solomon, 21 Forest.  
 1931 Gandy, Raymond Alfred, 57 Broad.  
 1913 Gandy, Raymond Reeves, 57 Broad.  
 1931 Giles, Newell Walton, 1 Atlantic.  
 1909 Godfrey, William Truitt, 65 South.  
 1939 Grady, Joseph Francis, 65 South.  
 1938 Grant, A. Nathaniel, 115 West Main.  
 1929 Hamilton, John Stewart Marshall, 88 South.  
 1937 Harrison, Francis Murphy, 512 Atlantic.  
 1908 Harrison, John Francis, 512 Atlantic.  
 1916 Henderson, Alfred Collard, 39 Broad.  
 1935 Henderson, Jean, 55 Glenbrook rd.  
 1901 Hertzberg, George Robert Reinhold, 40 South.  
 1930 Hertzberg, Reinhold Frederick, 227 Bedford.  
 1938 Hewitt, Alfred E., 510 Summer.  
 1937 Hopper, Edward Bernard, 58 South.  
 1937 Hymovich, Leo, 74 Park pl.  
 1929 Keddy, Russell Alfred, 65 South.  
 1938 Kezel, Albert Patrick C., 241 Fairfield ave.  
 1939 Koffler, Arthur, 71 River.  
 1939 Lynn, John Galloway, Stamford Hall.  
 1904 MacLean, Donald Robert, 31 West Park pl.  
 1934 Malloy, Edward Francis, 63 South.  
 1933 McFarland, Frederick William, 65 South.  
 1928 McGourty, Andrew Frederick, 7 Glenbrook rd.  
 1935 McGourty, David Philip, 25 Bedford.  
 1924 McMahan, Francis Cash, 62 Suburban ave.  
 1934 Meade, Charles Havelock Beverly, 433 Atlantic.  
 1930 Meschter, Eugene Funk, Yale & Towne Co.  
 1938 Murphy, Charles Anthony, 65 South.  
 1931 Murray, Henry Joseph, 53 South.  
 1911 Nemoitin, Jacob, 96 Main.  
 1928 Paul, Voyle Abrams, 58 South.  
 1938 Rawls, Edward Cotton, 1 Atlantic.  
 1929 Resnik, William Harry, 65 South.  
 1928 Root, Stella Quimby, 39 Broad.  
 1936 Rose, Samuel A., 25 Bedford.  
 1937 Rowell, E. Everett, 104 South.  
 1929 Rynard, William Morvel Wesley, 29 South.  
 1932 \*Schmidt, Norman Louis, 58 South.  
 1930 Sette, Alfred Joseph, 308 Atlantic.  
 1938 Sherman, Saul H., 81 Bedford st.  
 1909 Shirk, Samuel Martin, 218 Bedford.  
 1936 Shockley, Francis Milton, Stamford Hall.  
 1917 Smith, William Earl, 65 South.

1934 Starrett, Jay Ellis, 184 Bedford.  
 1907 Staub, John Howard, 100 South.  
 1931 Stone, Merlin Jones, 76 Glenbrook rd. Also 161  
 Mason, Greenwich.  
 1920 Stringfield, Oliver Linwood, 1416 Bedford st.  
 1937 Throckmorton, Verl John, Stamford Trust Bldg.  
 1931 Turnley, William Henry, 1 Atlantic st.  
 1934 Turton, Effie Howe, 90 Prospect.  
 1939 Washburn, Wendell James, 65 South.  
 1937 Weaver, Bruce S., 77 South.  
 1928 White, William Beverly, 322 Main.  
 1930 Wilson, Leo Earl, 87 South.

## GLENBROOK

1938 O'Meara, Francis Patrick, 1 Elm pl.  
 1885 Phillips, Alfred Noroton, Middlesex rd.

## SPRINGDALE

1937 Diamond, Edward H., 990 Hope.

## STRATFORD

1938 Ashcroft, Allan Davis, 3044 Main.  
 1938 Findorak, Francis George, 1882 Barnum ave.  
 1936 Friedman, Nathan H., 891 E. Broadway.  
 1927 Haberman, Chester Edward, 2921 Main.  
 1924 Heidger, Luther Caldwell, 972 E. Broadway.  
 1929 Hennessey, Edward Henry Joseph, 2390 Main.  
 1934 Maher, John Rodden, 2184 Main.  
 1931 Oesau, Harold Thomas, 1949 Main.  
 1937 Strayer, Estella M., 3486 Main.  
 1935 Strayer, Luther Milton, Jr., 3486 Main.

## TRUMBULL

## LONG HILL

1912 Smith, George Arthur.  
 1934 Wehger, Roland Theodore.

## WESTPORT

1904 Bill, Philip Worcester, 40 Thomas rd.  
 1930 Ellrich, David Lionel, 125 E. State.  
 1932 Gillette, Claude Wesley, 110 Charles.  
 1937 Hawley, George Waller, Box 710, Long Lots rd.  
 1937 Lynch, Hubbard, Evergreen ave.  
 1934 Morgan, William Oliver, 193 Main.  
 1927 Munson, William Russell, 20 Church lane.  
 1937 Nespor, Robert Venzel, 89 Main.  
 1925 Phillips, Harry Shaw, 44 E. Church.  
 1936 Teuscher, William P., 18 Compo rd.

## GREENS FARMS

1934 Smith, Stephen Munro, Box 31.

## WILTON

1939 Knauth, Marjorie S., Drum Hill rd.

## OUT OF COUNTY

1917 Powers, John H. T., 58 Federal st., Greenfield,  
 Mass.  
 1937 Geck, Otto Francis, Pomfret Center.  
 1939 Ireland, Richard Milton, 66 Bridge st., New Mil-  
 ford.  
 1939 Keating, John Joseph, 20 So. Main st., New Milford.  
 1933 Maddren, William Harvey, 126 Pine st., Freeport,  
 L. I.  
 1907 Pratt, Nathan Tolles, Old Saybrook.  
 1937 Millet, John Alfred Parson, 770 Park ave., N. Y. C.  
 1929 Salmond, Paul H., Box 39, North Battleford, Sas-  
 katchewan, Canada.

Total number 379



## HARTFORD COUNTY

*President*, HENRY N. COSTELLO, M.D., 179 Allyn Street, Hartford.

*Vice-President*, WILLIAM T. MORRISSEY, M.D., 55 W. Main Street, New Britain.

*Secretary*, FRANK T. OBERG, M.D., 689 Asylum Avenue, Hartford.

*Councilor*, EDWARD J. WHALEN, M.D., 750 Main Street, Hartford.

*Business Office*, 38 Prospect Street, Hartford.

## Censors

(One elected annually for a term of three years)

JOHN C. WHITE, M.D., 55 West Main Street, New Britain.

MAURICE T. ROOT, M.D., 51 North Main Street, West Hartford.

BENEDICT N. WHIPPLE, M.D., 45 N. Main Street, Bristol.

*Committee on Public Policy and Legislation*  
(State Committee member and one elected annually for a term of two years)

1940-1941 D. C. Y. MOORE, M.D., 689 Main Street, So. Manchester.

1940 BENJAMIN B. ROBBINS, M.D., 47 Main Street, Bristol.

*Committee on Medical Ethics and Deportment*  
(Two appointed annually by the President for a term of three years)

1940 ORAN A. MOSER, M.D., Elm Street, Rocky Hill.

1940 HOWARD A. BOYD, M.D., 937 Main Street, Manchester.

1941 WILLIAM F. FLANAGAN, M.D., 55 West Main Street, New Britain.

1941 C. BREWSTER BRAINARD, M.D., 50 Farmington Avenue, Hartford.

1942 WILLIAM R. HANRAHAN, M.D., 147 Main Street, Bristol.

1942 RICHARD E. DUNNE, M.D., 30 Farmington Avenue, Hartford.

THE PRESIDENT OF THE COUNTY MEDICAL ASSOCIATION.

THE SECRETARY OF THE COUNTY MEDICAL ASSOCIATION.

Annual Meeting, First Tuesday in April.

Semi-Annual Meeting, Fourth Tuesday in October.

## BERLIN

1908 Hodgson, Thomas Cady, Worthington Ridge.

## KENSINGTON

1938 LoVetere, Angelo Arthur, 528 Farmington.

## BLOOMFIELD

1936 Burgdorf, Alfred Louis, Duncaster rd.

## BRISTOL

1930 Appell, Paul Harry, 110 South.

1934 Beatrice, Alphonse Anthony, 331 Main.

1936 Bird, Frederick, Stanford, 9 N. Main.

1932 Borkowski, Boleslaus Joseph, 4 School.

1900 Brackett, Arthur Stone, 321 Main.

1923 Curtiss, Mabel Eloise, 81 Main.

1934 Donohue, Bartholomew Francis, 481 N. Main.

1935 Flynn, William Henry, 170 Main.

1925 Gore, Michael Alvord, 321 Main.

1937 Hall, Martin Irving, 269 N. Main.

1939 Hartin, Oliver Lilbourn, Bristol Hospital.

1921 Hanrahan, William Richard, 157 Main.

1938 Hudon, Frederick Alfred, 321 Main.

1928 LaPlume, Albert Antonio, 218 West.

1929 Nestos, Peter Alexander, 63 Main.

1935 Papa, John Smith, 124 Main.

1921 Park, Paul Archibald, 133 Main.

1921 Richardson, Ralph Augustus, 4 School.

1922 Robbins, Benjamin Bissell, 47 Main.

1935 Siliciano, Raoul Andrew Victorius, 110 South.

1936 Stevenson, William Robb, 7 Prospect St.

1939 Tirella, Fred. Francis, 481 N. Main.

1909 Whipple, Benedict Nolasco, 45 N. Main.

1934 Winters, Herman W., 405 N. Main.

## CANTON

## COLLINSVILLE

1906 Cox, Ralph Benjamin.

## EAST HARTFORD

1931 Brecker, Francis Wellington, 9 Burnside ave.

1937 Cornwell, Philip M., 970 Main.

1936 Gallivan, John Norman, 74 Connecticut blvd.

1927 Goddard, Harvey Burton, 970 Main.

1923 Haylett, Howard Bulkeley, 1109 Main.

1933 Houle, Raymond Theodore, 1010 Main.

1934 Lublin, Raymond David, 759 Main.

1937 McCue, Martin Patrick, 1429 Main.

1939 Mirabile, Thomas Joseph, 7 Woodbridge ave.

1916 Onderdonk, Harrie Jay, 61 Richard rd.

## EAST WINDSOR

## BROAD BROOK

1923 Robinson, Wilfred John Thomas, Main.

1937 Maslak, Rudolph, South Main, Warehouse Point.

## ENFIELD

## HAZARDVILLE

1906 Bridge, John Law, P.O. Box 272

1923 Shepherd, William Gordon, Main.

## THOMPSONVILLE

1937 Bloom, David Irving, 134 Pearl.

1937 Dignam, Barnard Stephen, 59 Pearl.

1906 Dowd, Michael Joseph, 25 Church.

1932 Fancher, Henry Wilson, 1070 Enfield.

1938 Gourlie, Howard Wallace, 53 New Kingst.

1932 McHugh, John Francis, 29 Central.

1916 Simonton, Frank Forester, 75 N. Main.

1928 Stein, Albert, 144 Pearl.

1917 Vail, Thornton Edwin, 124 Main.

## FARMINGTON

1933 Bunnell, Walls Willard, Main.

1933 Ellis, Francis Duffy, Jr., Elm Tree Inn.

## GLASTONBURY

1933 Earle, Benjamin Baylis, 404 Main.

1935 Griswold, Edwin Monroe, 419 Main.

1939 Raffa, Joseph, 2638 Main st.

1924 Whittles, Lee Jay, 351 Main.

## SOUTH GLASTONBURY

1908 Ward, James Ward, Station 57.

## GRANBY

1923 Pendleton, Ernest Raymond.

## HARTFORD

1927 Allen, Wilmar Mason, 20 S. Hudson.

1937 Andrews, Egbert Merrill, 648 Asylum.

1935 Angus, Leslie Robert, 200 Retreat ave.

1927 Antupit, Louis, 242 Trumbull.

1936 Apter, Harry, 1453 Main.

1932 Arons, Milton Robert, 1061 Albany ave.

1904 Backus, Harold Simeon, 99 Pratt.

- 1934 Bailey, Harry, 242 Trumbull.  
 1913 Bailey, Neil Herbert, 550 Main.  
 1923 Bancroft, Harold Arthur, 179 Allyn.  
 1933 Bausch, Carl Philipp, 36 Pearl.  
 1886 Beach, Charles Coffing, 54 Woodland.  
 1907 Beach, Charles Thomas, 50 Farmington ave.  
 1929 Beatman, Israel, 650 Main.  
 1934 Beizer, Edmund, 1711 Park.  
 1923 Bestor, Eugene Leonard, 36 Pearl.  
 1926 Bidgood, Charles Young, 179 Allyn.  
 1936 Bingham, Charles Tiffany, 751 Asylum ave.  
 1913 Biram, James Harrington, 179 Allyn.  
 1913 Birdsong, Julian Lee, 435 Farmington ave.  
 1938 Birge, Henry L., 179 Allyn.  
 1907 Blair, Edward Holden, 43 Farmington ave.  
 1897 Botsford, Charles Porter, 219 Collins.  
 1903 Brainard, Clifford Brewster, 50 Farmington ave.  
 1916 Branon, Anthony William, 179 Allyn.  
 1912 Brayton, Howard Wheaton, 179 Allyn.  
 1939 Brennan, Edward L., 74 Webster st.  
 1931 Brewer, Timothy Francis, 211 Church.  
 1929 Buck, Burdette Jay, 50 Farmington ave.  
 1931 Buckley, Richard Cotter, 683 Asylum ave.  
 1932 Burlingame, Clarence Charles, 200 Retreat ave.  
 1937 Burns, Maudie Marie, State Office building.  
 1928 Butler, Nicholas George, 50 Farmington ave.  
 1931 Calverley, Eleanor Jane Taylor, 143 Sigourney.  
 1914 Cantarow, Daniel, 10 Garden.  
 1934 Capiello, Silvestro, 97 Vine.  
 1933 Carey, Thomas Cornelius, 50 Farmington ave.  
 1931 Carniglia, Ettore Francis, 50 Farmington ave.  
 1929 Carroll, James Edward, 220 Farmington ave.  
 1915 Carter, Earle Buell, 99 Pratt.  
 1930 Caulfield, Ernest Joseph, 683 Asylum ave.  
 1933 Cenci, Vincent Peter, 242 Trumbull.  
 1935 Clarke, Ralph deBallard, "Cedarcrest."  
 1922 Clason, Freeman Pell, 179 Allyn.  
 Clifford, Martha Louise, 165 Capitol ave.  
 1905 Clifton, Harry Colman, 30 Farmington ave.  
 1931 Climan, Max, 242 Trumbull.  
 1896 Cochran, Levi Bennett, 50 Farmington ave.  
 1928 Cogan, George Eugene, 50 Farmington ave.  
 1913 Cogswell, Eliot Sanborn, 179 Allyn.  
 1936 Cogswell, Lawrence Perley, 50 Farmington ave.  
 1938 Cohn, Samuel Hills, 715 Asylum.  
 1935 Connor, Joseph Joyce, 750 Main.  
 1933 Corcoran, Michael Anthony, 41 Webster.  
 1913 Costello, Henry Nicholas, 179 Allyn.  
 1924 Couch, Arthur Rockwell, 95 Farmington ave.  
 1921 Cragin, Donald Brett, 151 Farmington ave.  
 1933 Crosby, Edward Harding, 50 Farmington ave.  
 1936 Cunningham, James Morrow, 165 Capitol ave.  
 1914 Daly, Charles William, 750 Main.  
 1935 Daly, William Patrick, 342 Edgewood.  
 1929 Davenport, Anna Keith Prentiss, 54 Church.  
 1932 Dawson, Lionel Montrose, 700 Main.  
 1909 DeBonis, Domenico A., 183 Westland.  
 1930 Dignam, Edward Anthony, 750 Main.  
 1914 Deming, Clinton Demas, 179 Allyn.  
 1914 Deming, Edward Adams, 715 Asylum ave.  
 1931 DePasquale, Francis Lawrence, 1026 Main.  
 1937 DePasquale, John Anthony, 525 Main.  
 1934 DeVito, Michael Joseph, 1039 Main.  
 1931 Dion, Asa Joseph, 207 Washington.  
 1939 Dodd, Burwell, 689 Asylum.  
 1934 Donner, Samuel, 99 Pratt.  
 1938 Donovan, William Francis, 47 Main.  
 1937 Duffy, Leo Thomas, 214 Franklin ave.  
 1923 Dunne, Richard Edwin, 50 Farmington ave.  
 1938 Durkee, Ralph Everett Jr., 179 Allyn.  
 1916 Dwyer, William, 18 Asylum.  
 1927 Elliott, Kirkor Gregory, 631 Park.  
 1937 Ellison, Frederick Speirs, 50 Farmington ave.  
 1895 Elmer, Edward Oliver, 1731 Park.  
 1914 Emmett, Francis Arthur, 410 Asylum.  
 1937 Fagan, Francis X., 68 Pratt.  
 1933 Farland, Victor Louis, 54 Pratt.  
 1919 Fay, William James, 179 Allyn.  
 1929 Felty, Augustus R., 846 Asylum ave.  
 1934 Finley, George Clark, 50 Farmington ave.  
 1913 Flaherty, Claude Vincent, 50 Farmington ave.  
 1939 Flaherty, Hugh F., 655 Maple ave.  
 1931 Friery, Clarence Milton, 110 Greenfield.  
 1919 Furniss, Henry Watson, 1335 Main.  
 1927 Gaberman, David, 179 Allyn.  
 1937 Galinsky, David, 853 Wethersfield ave.  
 1921 Garland, Robert Bernard, 597 Broad.  
 1898 Gill, Michael Henry, 36 Pearl.  
 1922 Gills, William Lee, 179 Allyn.  
 1934 Giorgio, Nicholas Anthony, 61 Edwards.  
 1937 Giuliano, Sebastian, 468 Franklin ave.  
 1935 Glass, George Courtenay, 476 Farmington ave.  
 1934 Glaubman, Henry Mitchell, 20 Lenox.  
 1927 Goff, Charles Weer, 30 Farmington ave.  
 1936 Gold, Louis Henry, 412 Farmington ave.  
 1930 Goldenberg, Jacob Joseph, 629 Albany ave.  
 1933 Goodell, Robert Alvan, 79 Elm.  
 1900 Goodrich, Charles Augustus, 5 Haynes.  
 1919 Gosselin, George Adolor, 50 Farmington ave.  
 1935 Gould, Max Martin, 434 Main.  
 1923 Grau, Leroy Charles, 700 Main.  
 1923 Graves, James Chapman, 700 Main.  
 1909 Griswold, Arthur Heywood, 179 Allyn.  
 1924 Griswold, Matthew Hammond, 165 Capitol ave.  
 1921 Grosvenor, Frank Livingstone, 700 Main.  
 1930 Hall, Llewellyn, 79 Elm.  
 1939 Hall, Wendell Charles, 179 Allyn st.  
 1913 Harrington, Amos Thomson, 43 Farmington ave.  
 1936 Harvey, Daniel Foster, 218 No. Beacon St.  
 1938 Harris, Louis David, 242 Trumbull.  
 1930 Hastings, Louis Pease, 370 Collins.  
 1908 Hatheway, Clarence Morris, 110 High.  
 1937 Hazen, Donald Robert, 179 Allyn.  
 1907 Hepburn, Thomas Norval, 179 Allyn.  
 1930 Heyman, Joseph, 650 Main.  
 1934 Hirschfeld, Otto Max, 1037 Albany ave.  
 1931 Hirshberg, Manuel Shelton, 650 Main.  
 1925 Hoffman, Charles Curtis, 700 Main.  
 1924 Hogan, Walter Louis, 750 Main.  
 1929 Holt, Kerchival Rogers, 50 Farmington ave.  
 1930 Holtz, Raymond Sidney, 242 Trumbull.  
 1934 Horning, Benjamin Graham, 550 Main.  
 1935 Hough, Perry Tyler, 179 Beacon.  
 1922 Howe, Glover Elbridge, 179 Allyn.



- 1936 Hurwitz, George Hillel, 75 Pearl.  
 1920 Hurwitz, Herman Max, 75 Pearl.  
 1917 Hutchison, James Elder, 125 Trumbull.  
 1938 Hutton, Gordon Hobbs, 181 Grandview ter.  
 1924 Ingraham, A. Elizabeth, 302 Wolcott Hill rd.,  
 Wethersfield.  
 1937 Irving, James Grant, 151 Farmington ave.  
 1934 James, Lewis Paul, 68 Pratt.  
 1912 Jarvis, Henry Gildersleeve, 179 Allyn.  
 1930 Jones, Frank Stafford, 179 Allyn.  
 1928 Kalin, Jacob Isaac, 286 Church.  
 1933 Kardys, John Albert, 487 Main.  
 1935 Karotkin, Robert Harold, 839 Albany ave.  
 1935 Kaschmann, Joseph, 445 Farmington ave.  
 1937 Katz, Dewey, 361 Linnmoore.  
 1924 Katz, Henry, 750 Main.  
 1926 Keefe, George Gregory, 30 Sisson ave.  
 1934 Keefe, Raymond Starkey, 272 Franklin ave.  
 1934 Keefe, Walter Joseph, 30 Sisson ave.  
 1908 Keith, Albert Russell, 50 Farmington ave.  
 1920 Kelly, Claude Currie, 179 Allyn.  
 1930 Kendall, Ralph Emerson, 20 S. Hudson.  
 1927 Kilbourn, Austin, 580 Asylum.  
 1920 Kilbourn, Joseph Birney, 36 Pearl.  
 1906 Kingsbury, Isaac William, 125 Trumbull.  
 1937 Kleiman, Abraham Ober, 750 Main.  
 1932 Klein, Abraham Arthur, 509 Farmington ave.  
 1925 Knowlton, Millard, 165 Capitol ave.  
 1930 Kunkel, Frederick Earle, 179 Allyn.  
 1901 Lampson, Edward Rutledge, 179 Allyn.  
 1938 Lampson, Rutledge Starr, 179 Allyn.  
 1913 Landry, Arthur Bernard, 50 Farmington ave.  
 1926 Landry, Benedict Bernard, 50 Farmington ave.  
 1929 Larrabee, John Whitfield, 650 Main.  
 1895 Lawton, Franklin Lyman, 580 Farmington ave.  
 1920 Leichner, William, 66 Farmington ave.  
 1933 Levin, Albert Elliot, 242 Trumbull.  
 1935 Levine, Sinclair Simcha, 54 Church.  
 1938 Lewis, Henry Ryle, 200 Retreat ave.  
 1937 Lischner, Moses David, 650 Main.  
 1934 Little, Milton Frederick, 49 Pearl.  
 1915 Locke, Harry Leslie Franklin, 179 Allyn.  
 1923 Luby, Thomas John, 410 Asylum.  
 1913 Madden, Leon Irving, 50 Farmington ave.  
 1919 Maislen, Samuel, 2138 Main.  
 1931 Mancoll, Morris Max, 242 Trumbull.  
 1932 Marrazini, Samuel, 763 Albany ave.  
 1930 McClellan, Wilbert Ernest, 750 Main.  
 1898 McCook, John Butler, 390 Main.  
 1936 McCormack, Christopher Joseph, 50 Farmington  
 ave.  
 1938 McCrann, Donald Joseph, 50 Farmington ave.  
 1934 McDermott, John Francis, 750 Main.  
 1933 McGrath, John Francis, 663 Maple ave.  
 1934 McLean, John Joseph, 650 Main.  
 1932 McLellan, Philip Garretson, 683 Asylum ave.  
 1935 McNulty, Terence Francis, 21 Sisson ave.  
 1907 McPartland, Patrick Farrell, 410 Asylum.  
 1916 McPherson, Sidney Horace, 4 Atwood.  
 1933 Middlebrook, Louis Francis Jr., 689 Asylum ave.  
 1935 Mikolainis, Mindaugis Vincent.  
 1916 Miller, James Raglan, 179 Allyn.  
 1933 Mirabile, Charles Samuel, 179 Allyn.  
 1937 Montano, Rocco Anthony, 242 Trumbull.  
 1938 Montano, Charles Carl, 525 Main.  
 1909 Morrissey, Michael James, 18 Asylum.  
 1927 Moylan, Thomas Patrick, 50 Farmington ave.  
 1930 Moyle, Henry Brown, 488 Main.  
 1919 Murphy, James Edward, 179 Allyn.  
 1935 Murphy, Thomas Francis, 619 Park.  
 1897 Naylor, James Henry, 1 Main.  
 1938 Neidlinger, William James, 751 Asylum ave.  
 1926 Oberg, Frank Thorwald, 689 Asylum ave.  
 1923 O'Connell, John Francis, 865 Park.  
 1928 O'Connell, Maurice Francis, 50 Farmington ave.  
 1902 O'Flaherty, Ellen Pembroke, 140 Main.  
 1928 Ogden, Ralph Trafton, 179 Allyn.  
 1931 Olmsted, John Gerald Maurice, 404 Farmington  
 ave.  
 1937 O'Neill, Charles William, 18 Asylum.  
 1921 Osborn, Stanley Hart, 165 Capitol ave. Home  
 address: 41 Brace rd., W. Hartford.  
 1927 Osmond, Robert Hunter, 50 Farmington ave.  
 1906 Outerson, Richard Ambrose, 50 Farmington ave.  
 1938 Padula, Vincent Domenica, 132 N. Britain ave.  
 1933 Paladino, Joseph Salvator, 300 Franklin ave.  
 1919 Parker, John Woodcock, 84 Forest.  
 1926 Partridge, Winthrop Prescott, 403 Farmington ave.  
 1938 Peacock, Albert Upham, 751 Asylum ave.  
 1933 Phelps, Maxwell Overlock, 594 Farmington ave.  
 1937 Phelps, Paul Stetson, 199 S. Beacon.  
 1929 Pike, Maurice Mitchell, 179 Allyn.  
 1934 Preston, Thomas Raymond, 65 Kenyon.  
 1936 Quarrier, Sidney Sayre, 751 Asylum ave.  
 1923 Radin, Morris Jacob, 650 Main.  
 1928 Radom, Myron Michael, 242 Trumbull.  
 1923 Rankin, Bertrand Fred, 57 Pratt.  
 1913 Reardon, William Francis, 750 Main.  
 1934 Reidy, David Dillon, 750 Main.  
 1927 Resnisky, Andrew Francis, 57 Pratt.  
 1928 Reynolds, Harry St. Clair, 410 Asylum.  
 1916 Reynolds, Harry Stephen, 18 Asylum.  
 1930 Reynolds, Robert Gardner, 179 Allyn.  
 1922 Roberts, Douglas James, 179 Allyn.  
 1932 Robinson, Albert James, 55 Elm.  
 1937 Rogers, Frederick Peckham, 50 Farmington ave.  
 1934 Rollins, Henry Brock, 140 Garden.  
 1932 Romaniello, Rocco John, 415 Hillside ave.  
 1909 Rooney, James Francis, 410 Asylum.  
 1936 Rosenbaum, George Jonas, 647 New Britain ave.  
 1938 Rosenthal, Ernest, 18 Asylum.  
 1935 Roth, Frank Edward, 650 Main.  
 1900 Rowley, Alfred Merriman, 179 Allyn.  
 1910 Rowley, John Carter, 1046 Asylum ave.  
 1907 Rowley, Robert Lee, 79 Elm.  
 1921 Russell, George Gardiner, 179 Allyn.  
 1936 Ryan, Francis James, 439 Farmington ave.  
 1937 Sayers, John Joseph, 656 Park.  
 1923 St. John, Leopold Albert, 25 Charter Oak ave.  
 1926 Salvin, Benjamin Lloyd, 242 Trumbull.  
 1932 Samponaro, Nicholas, 650 Main.  
 1928 Scafarello, Peter Joseph, 410 Asylum.  
 1932 Schaefer, Abraham Maurice, 262 Maple ave.

- 1920 Shaefer, Jacob, 750 Main.  
 1934 Schuman, David Harry, 909 Albany ave.  
 1923 Scudder, Winthrop Davis, 179 Allyn.  
 1887 Segur, Gideon Cross, 67 Farmington ave.  
 1932 Seibert, Alfred Frank, 700 Main.  
 1923 Seigall, Harry Arthur, 750 Main.  
 1920 Shafer, Alexander Samuel, 68 Pratt.  
 1939 Sharp, Louis Inman, 200 Retreat ave.  
 1928 Shaw, George Hamill, 700 Main.  
 1920 Shea, Daniel Edward, 750 Main.  
 1933 Shulman, David Nathaniel, 422 Farmington ave.  
 1932 Sigal, Jacob Bernard, 99 Pratt.  
 1936 Slossberg, David Seymour, 541 Park.  
 1901 Smith, Earl Terry, 36 Pearl.  
 1925 Smith, George Mortimer, 700 Main.  
 1937 Sneiderman, George Irving, 18 Asylum.  
 1929 Snelling, Pinckney Welch, 179 Allyn.  
 1938 Souther, Susan Page, State Office Building.  
 1937 Spekter, Louis, 580 Asylum ave.  
 1921 Spillane, Bernard, 30 Farmington ave.  
 1927 Standish, Erland Myles, 179 Allyn.  
 1935 Standish, Hilda Crosby, 100 Retreat ave.  
 1897 Standish, James Herbert, 701 Albany ave.  
 1931 Standish, Welles Adams, 701 Albany ave.  
 1905 Starr, Robert Suthoss, 179 Allyn.  
 1930 Steincrohn, Peter Joseph, 705 Asylum ave.  
 1902 Steiner, Walter Ralph, 646 Asylum ave.  
 1935 Stempa, Henry, "Cedarcrest".  
 1930 Stephenson, Charles Wattles, 179 Allyn.  
 1919 Stockwell, William Myron, "Cedarcrest".  
 1938 Stolzheise, Ralph Merwin, 200 Retreat ave.  
 1903 Storrs, Eckley Raynor, 179 Allyn.  
 1923 Storrs, Ralph Warren, 179 Allyn.  
 1923 Stoughton, Dwight Harold, 247 S. Whitney.  
 1908 Swan, Horace Cheney, 196 N. Whitney.  
 1914 Sweet, John Henry Throop, Jr., 179 Allyn.  
 1905 Swett, Paul Plummer, 4 Atwood.  
 1932 Talbot, Henry Pierce, 165 Capitol ave.  
 1906 Taylor, Maude Winifred, 47 Willard.  
 1921 Thenebe, Carl Leonard, 68 Pratt.  
 1922 Thompson, Hartwell Greene, 179 Allyn.  
 1938 Tonken, Louis Clarence, 485 Farmington ave.  
 1938 Tovell, Ralph Moore, Hartford Hospital.  
 1930 Townsend, Wilmot Charles, 50 Farmington ave.  
 1912 Truex, Edward Hamilton, 99 Pratt.  
 1908 Tuch, Morris, 99 Pratt.  
 1907 Turbert, Edward Joseph, 703 Asylum ave.  
 1937 Unsworth, Arthur Charles, 49 Pearl.  
 1933 Uricchio, Joseph George, 260 Wethersfield ave.  
 1908 Vail, George Francis, 36 Pearl.  
 1923 VanKleeck, Euen, 700 Main.  
 1904 VanStrander, William Harold, 179 Church.  
 1926 VanWart, William Haley, 650 Main.  
 1917 Vernlund, Carl Frithiof, 179 Allyn.  
 1921 Vershow, Nathan, 28 Sisson ave.  
 1914 Waite, Robert Lester, 68 Pratt.  
 1932 Wallace, Charles Kenneth, 700 Main.  
 1937 Walton, Loftus Linwood, 179 Allyn.  
 1932 Warring, Howard Lewis, 1756 Main.  
 1934 Winer, Julius Gills, 750 Main.  
 1931 Weisenfeld, Nathan, 169 Church.  
 1936 Weissenborn, Walter, 50 Farmington ave.  
 1907 Welch, Thomas Francis, 50 Farmington ave.  
 1920 Weld, Stanley Burnham, 179 Allyn.  
 1916 Wells, Donald Breckenridge, 580 Asylum.  
 1922 Wentworth, John Alexander, 50 Farmington ave.  
 1924 Whalen, Edward Joseph, 750 Main.  
 1938 White, Benjamin Uroon, 179 Allyn St.  
 1907 Wiedman, Otto George, 179 Allyn.  
 1931 Wienski, John Casimer, 502 Park.  
 1935 Wilson, Charles Christopher, 249 High.  
 1907 Wilson, James Cornelius, 179 Allyn.  
 1930 Wilson, William Augustus, 683 Asylum ave.  
 1904 Witter, Orin Russell, 179 Allyn.  
 1933 Wood, Frank Oliver, 404 Farmington ave.  
 1934 Woodford, Chester North, 703 Asylum ave.  
 1923 Woodson, Jacob Tyree, 179 Allyn.  
 1916 Worthen, Thacher Washburn, 179 Allyn.  
 1922 Wright, William Witter, 700 Main.  
 1932 Wulp, George Adolf, 50 Farmington ave.  
 1912 Yergason, Robert Moseley, 50 Farmington ave.  
 1939 Yost, Orrin Rose, 200 Retreat ave.  
 1938 Young, William Greenhill, 200 Retreat ave.  
 1928 Zariphes, Constantine Argyros Paleslogos, 96 Main.  
 1934 Zeman, Burnhardt, 1269 Main.

## MANCHESTER

- 1924 Boyd, Howard, 935 Main.  
 1936 Keeney, Robert Raymond, Jr., 791 Main.  
 1925 Knapp, Robert Phineas, 147 Hartford rd.  
 1937 Sundquist, Alfred Bernhardt, 843 Main.  
 1936 Zaglio, Edmond Robert, 12 Myrtle.

## SOUTH MANCHESTER

- 1926 Caldwell, David Manchester, 935 Main.  
 1926 Friend, Amos Edgar, 935 Main.  
 1927 Higgins, Edwin Carlton, 875 Main.  
 1921 Lundberg, George Albin Ferdinand, 755 Main.  
 1908 May, George William, 186 E. Center.  
 1916 Moore, Demarquis DeCasso Ye Rujo, 689 Main.  
 1930 Moriarty, Mortimer Emmett, 905 Main.

## NEW BRITAIN

- 1932 Benoit, Raoul Joseph, 272 Main St.  
 1934 Bernstein, Dwight J., 55 West Main.  
 1930 Blogoslawski, Walter Joseph, 419 Main.  
 1909 Bodley, George Houghton, 155 W. Main.  
 1935 Bristoll, Donald Andrews, 55 W. Main.  
 1927 Buol, Robert Stanley, 99 W. Main.  
 1935 Chalmers, Harriet Elizabeth, 45 Walnut.  
 1926 Chernaik, Samuel Julius, 300 Main.  
 1913 Cooley, Clifton Mather, 44 S. High.  
 1939 Daley, Louis W., 99 W. Main.  
 1938 Dalton, George Henry, 99 W. Main.  
 1931 Darrow, John Edward, 55 W. Main.  
 1928 Donnelly, Stephen Patrick, 55 W. Main.  
 1934 Dray, Edward Joseph, 259 Main.  
 1915 Dunn, George Washington, 55 W. Main.  
 1936 Enander, Fred Conrad, 25 Arch.  
 1923 Flanagan, William Francis, 55 W. Main.  
 1931 Geetter, Isadore Stolper, 92 Grand.  
 1921 Grant, Arthur Sheldon, 55 W. Main.  
 1937 Hart, Carl J., 259 Main.  
 1930 Kalett, Joseph, 99 W. Main.  
 1924 Kinsella, Gertrude Christine Johnson, 52 Main.



- 1924 Kinsella, Michael Allen, 52 Main.  
 1926 Lekston, Roman Francis, 197 W. Main.  
 1931 Marsh, Milton Loveland, 272 Main.  
 1930 Matteis, Joseph Theodore, 55 W. Main.  
 1939 McMahon, George William, 272 Main.  
 1934 Michalowski, Valerian Stanislaus, 561 Main.  
 1937 Miller, Harry Bomard, 81 W. Main.  
 1935 Moorad, Philip Jacob, 55 W. Main.  
 1912 Morrissey, William Thomas, 55 W. Main.  
 1923 Mouradian, Mary Garoudy, 87 Prospect.  
 1938 Orbach, Egmont Julius, 81 W. Main.  
 1938 Parlato, N. Anthony, 99 W. Main.  
 1939 Paolillo, Charles Gerald, 99 W. Main.  
 1939 Pola, William Edward, 99 W. Main.  
 1938 Perakos, George Peter, 300 Main.  
 1930 Pullen, Richard Woollard, 55 W. Main.  
 1930 Purney, John, 99 W. Main.  
 1936 Resnik, Edward, 166 Main.  
 1930 Schechtman, Charles Theodore, 81 W. Main.  
 1931 Schupack, Samuel David, 99 W. Main.  
 1938 Scully, Roger Tehan, 92 Hart.  
 1930 Slys, Ladislaus Bernard, 589 Main.  
 1928 Smith, Vincent Joseph, 55 W. Main.  
 1936 Squillacote, Vincent Joseph, 33 So. High.  
 1938 Sullivan, Charles Moyer, 55 W. Main.  
 1935 Tokarczyk, John Joseph, 32 North.  
 1923 Tutles, Amelia Veronica, 272 Main.  
 1928 Waskowitz, David, 81 W. Main.  
 1932 White, John Cowles, 55 W. Main.
- NEWINGTON
- 1938 Freeman, John Jay, 1100 Main.  
 1936 Maher, Thomas Francis, Veterans Administration Facility.  
 1934 Sills, Theodore Hopkins, 866 Main.
- PLAINVILLE
- 1878 Bull, John Norris, 57 Whiting.  
 1931 Cook, George Francis, 4 East Main.  
 1931 Frost, Lawrence Hubbard, 98 W. Main.  
 1934 Menousek, Joseph Albert, 14 E. Main.  
 1938 Tortolani, Aresto Peter, 75 E. Main.
- PLANTSVILLE
- 1937 Connor, George Michael, 772 S. Main.
- ROCKY HILL
- 1904 Moser, Oran Alexander, Elm.
- SIMSBURY
- 1925 Murphy, Owen Lee, Weatogue.  
 1932 Stretch, James Edison, N. Main.
- SOUTHINGTON
- 1935 Dudac, Thomas William, 9 Center.  
 1933 Gura, George Michael, 22 Main.  
 1935 Nagle, William Thomas, 23 Woodruff.  
 1929 Simmons, Eric Melville, Main.  
 1929 Thalberg, Reuben Edward, 32 N. Main.
- SUFFIELD
- 1938 Cogteo, Stephen Paul, 328 Main.  
 1929 Levy, William, 339 Main.  
 1930 Upton, William Hart, 394 Main.
- UNIONVILLE
- 1937 Dunne, Edward Patrick, Main.
- WEST HARTFORD
- 1931 Case, Edward Percy, 28 Brunswick ave.  
 1932 Crawley, George Andrew, 330 Park rd.
- 1928 Cushman, Laurence Arnold, 23 S. Main.  
 1922 Davis, James Edward, 1961 Boulevard.  
 1910 Denne, Thomas Harman, 39 N. Main.  
 1921 Dinsmore, William Wert, 28 Bainbridge rd.  
 1938 Foote, Franklin Manly, 100 Dover rd.  
 1926 Glazier, J. Raymond, 26 Sequin rd.  
 1939 Gray, Albert Stanley, 1271 Farmington ave.  
 1938 Gray, Harry Joshua, 8 Newport ave.  
 1930 Griggs, John Bolter, 38 Orchard rd.  
 1932 Lundborg, Francis Ludwig, 31 N. Main.  
 1930 Lynch, John Francis, 42 Whetton rd.  
 1935 MacLean, Ethel Margaret, 32 Bishop rd.  
 1935 Martin, John Garthwaite, 7 S. Main.  
 1939 Murphy, Thomas Denis, 957 Farmington ave.  
 1938 O'Malley, Martha Alice, 461 Prospect ave.  
 1930 Parshley, Philip Ford, 20 S. Quaker lane.  
 1924 Root, Maurice Timothy, 51 N. Main.  
 1935 Root, Sophie Townsend, 51 N. Main.  
 1927 Standish, Erland Myles, Greenridge Lane, Sunset Farms.  
 1936 Stewart, Lester Quentin, 69 S. Main.  
 1937 Tait, Arthur Alfred, 333 Park rd.  
 1930 Taylor, Andrew, 58 Griswold dr.  
 1934 Winters, John Thomas, 3 S. Main.
- WETHERSFIELD
- 1938 Carvey, Edward Vincent, 28 Marsh.  
 1933 Howard, Harold Amasa, 330 Main.  
 1934 Priddy, Foster Eugene, Box 145.  
 1927 Smith, William Bowers, 91 Center.  
 1932 Storms, William Frederick, 147 Main.
- WINDSOR
- 1930 MacCready, William Harold, 38 Elm.  
 1924 Pratt, Aaron Paul, 253 Broad.
- WINDSOR LOCKS
- Coyle, Anna E. H., 16 Church.  
 1937 Coyle, Bruce James, 2 Chestnut.  
 1934 Whitford, Warren, 134 Main.
- OUT OF COUNTY
- 1905 Burr, Noah Arthur, Higganum.  
 1930 Byrne, David Walter, The Presbyterian Hospital, Broadway and 165th St., N. Y. C.  
 1911 Cobb, Albert Edward, Canaan.  
 Curtis, Burr K., 25 Prospect pl., N. Y. C.  
 1900 Enders, Thomas Burnham, Mystic.  
 1932 Filson, Ralph Marshall, 107 Tullamore Road, Garden City, L. I., N. Y.  
 1936 Lewis, Samuel D., 515 E. 4th St., Brooklyn, N. Y.  
 1928 Mahoney Daniel F. C., P. O. Box 908, Palm Springs, Calif.  
 1937 Pekala, Joseph Gabriel, 261 Main St., Northampton, Mass.  
 1934 Prout, Curtis Tuttle, 163 Hillside Ave., Arlington Hts., Mass.  
 1902 Purinton, Charles Oscar, U. S. Veterans Hospital, Sunmount, N. Y.  
 1937 Shaffer, Thomas Eugene, 303 Whitney Ave., New Haven.  
 1933 Smith, Harry B., 414 Broad St., Marianna, Florida.  
 1937 Twaddle, Paul H., Penn. Hospital, 8th and Spruce St., Phila., Pa.  
 1934 Watson, William James, Apt. 410, 4111 Walnut St., Phila., Pa.

- 1923 Walker, William Hastings, Newtown.  
 1938 Whitcomb, Benjamin Bradford, New Haven  
 Hospital, New Haven.

Total number 532

### LITCHFIELD COUNTY

*President*, EDWIN G. READ, M.D., Main Street, Water-  
 town.

*Vice-President*, ROY V. ANDERSON, M.D., 570 Main Street,  
 Winsted.

*Secretary*, W. BRADFORD WALKER, M.D., Cornwall.

*Councilor*, CHARLES H. TURKINGTON, M.D., On-the-  
 Green, Litchfield.

#### *Censors*

(One elected annually for a term of three years)

HARRY B. HANCHETT, M.D., 55 Main Street, Tor-  
 rington.

1937 FORBES S. ADAM, M.D., Canaan.

1938 FREDERIC W. WERSEBE, M.D., Washington.

*Committee on Public Policy and Legislation*

(Elected annually)

SANFORD H. WADHAMS, M.D., 908 Main Street, Torrington,  
*Chairman*.

ELIAS PRATT, M.D., 27 Daycoeton Place, Torrington.

CHARLES H. TURKINGTON, M.D., On-the-Green, Litch-  
 field.

*Committee on Medical Ethics and Deportment*

(Appointed by President until removed or  
 successor appointed)

HARRY B. HANCHETT, M.D., 55 Main Street, Torrington,  
*Chairman*.

JEROME S. CHAFFEE, M.D., Main Street, Sharon.

WINFIELD WIGHT, M.D., Goodwin Court, Thomaston.

ELIAS PRATT, M.D., 27 Daycoeton Place, Torrington.

CHARLES H. TURKINGTON, M.D., On-the-Green, Litch-  
 field.

W. BRADFORD WALKER, M.D., Cornwall, *Recorder*.

Annual Meeting, Fourth Tuesday in April.

Semi-Annual Meeting, First Tuesday in October.

### CORNWALL

1922 Walker, Wilmarth Bradford.

#### CORNWALL BRIDGE

1938 Clarke, William C.

1931 Evarts, Josephine, Warren rd.

#### KENT

1938 Bruyere, Paul Tulane, Kent School.

#### LITCHFIELD

1921 Childs, Albert Ewing, North rd.

1935 Kilgus, John Frank, Jr., West.

1910 Turkington, Charles Henry, On-the-Green.

1896 Warner, Charles Norton, North.

1939 Warner, Charles Norton, Jr., North.

1936 Wray, Edward Halloway, Jr., Torrington rd.

#### NEW HARTFORD

1937 Ashley, Homer Champion, Main.

1930 Hoffman, Wallace Ellsworth, Box 458.

#### NEW MILFORD

1938 Day, Rupert S.

1938 Ignace, Stephen J.

1938 Stevens, Howard G.

#### NORFOLK

1937 Barstow, Richard Iddings, The Village Green.

1909 Pinney, Almon William, Greenwoods rd., E.

1934 Ursone, Frank Domenico, Greenwoods rd., W.

### NORTH CANAAN

#### CANAAN

1929 Adam, Forbes Sampson.

1935 Elliott, John Richard.

1924 Sellew, Robert Cowan.

1938 Sellew, Robert Cowan, Jr.

### PLYMOUTH

#### TERRYVILLE

1913 Lawton, Richard John, 9 N. Main.

1939 Wilcox, Lloyd Mather, Box 205.

### SALISBURY

#### LAKEVILLE

1933 Herrick, Francis Leach.

1923 Peterson, Clark Kimball.

1917 Tuttle, Albert Lake.

1936 Wieler, Harry Julius, Hotchkiss School.

### SHARON

1904 Chaffee, Jerome Stuart, Main.

1931 Hansell, Howard Russell, W. Main.

### THOMASTON

1938 Atha, Henry George.

1928 Curran, Harold Joseph, Main.

1903 Hazen, Robert, Union.

1910 Kane, James Hugh, S. Main.

1922 Wight, Winfield Emmons, Goodwin Court.

### TORRINGTON

1898 Barker, Abram James, 216 Main.

1937 Bienkowski, Joseph George, 40 Main.

1898 Carlin, Charles Henry, 236 Main.

1930 Danaher, Thomas Joseph, 106 Litchfield.

1935 Garston, Louis Edward, 49 Main.

1931 Giobbe, Michael Edward, 24 E. Main.

1936 Goldberg, Isadore Solomon, 5 Water.

1908 Hanchett, Harry Bigelow, 55 Main.

1936 Hill, Emerson Stanley, 53½ Main.

1917 Kennedy, William Clement, 106 Main.

1938 Kott, Joseph Henry, 199 Main.

1936 LoRusso, Domenico Leonardo, 40 Main.

1938 Morcko, William John, 201 East Pearl.

1923 Oelschlegel, Herbert Charles, 19 Maiden lane.

1938 Orlowski, Andrew William, 70 Main.

1923 Polito, Frank Leonard, 16 Litchfield.

1887 Pratt, Elias, 27 Daycoeton pl.

1904 Ryan, Timothy Mayher, 24 Mason.

1936 Sutherland, Francis Alexander, 24 Mason.

1917 Thomson, Thomas Leonard, 24 Mason.

1898 Wadhams, Sanford Hosea, 908 Main.

1917 Weed, Floyd Albert, 13 Main.

1937 Wilens, Gustav, 40 Main.

### WASHINGTON

1927 Jackson, Arthur Hartt.

1908 Wersebe, Frederic William.

### WATERTOWN

1936 Cleary, Harold John, Main.

1897 Loveland, Ernest Kilborn, 48 North.

1936 Meyers, Royal Abbott, 162 Main.

1919 Reade, Edwin Godwin, Main.

### WINCHESTER

#### WINSTED

1938 Baker, Philip George, 442 Main.



- 1936 Cornelio, Francis Joseph, 153 Main.  
 1933 Derwin, James Joseph, 350 Main.  
 1915 English, Chester Ferrin, 64 Main.  
 1937 Gallo, Francis, 384 Main.  
 1927 Herman, Donald Warner, 486 Main.  
 1936 Levy, Aaron, 384 Main.  
 1912 Reidy, Maurice Joseph, 350 Main.  
 1922 Sanderson, Roy Voter, 570 Main.

## WOODBURY

- 1913 Allen, Howard Sanford.  
 1937 Reichenbach, Frank.

## OUT OF COUNTY

- 1881 Platt, William Logan, State Hospital, P. O. Box 476, Norwich.  
 1914 Woodward, Harold Burton, 321 Main St., Bristol.  
 Total number 78.

## MIDDLESEX COUNTY

*President*, G. MANSFIELD CRAIG, M.D., 119 Main Street, Middletown.

*Vice-President*, CARL CHASE, M.D., Professional Building, Middletown.

*Secretary*, CHARLES RUSSMAN, M.D., Connecticut State Hospital, Middletown.

*Councilor*, ROY L. LEAK, M.D., Connecticut State Hospital, Middletown.

## Censors

(One elected annually for a term of three years)

PHILIP SCHWARTZ, 255 Main Street, Portland.

NORMAN GISSLER, 164 Court Street, Middletown.

## Committee on Public Policy and Legislation

(Appointed until removed or successor appointed)

G. MANSFIELD CRAIG, *President*, 363 Main Street, Middletown

CARL CHASE, *Vice-President*, Professional Building, Middletown

CHARLES RUSSMAN, *Clerk*, Conn State Hospital, Middletown

HARRY S. FRANK, 144 Washington Street, Middletown

## Committee on Medical Ethics and Department

(Two appointed biennially by the President for a term of six years)

1940 JESSIE W. FISHER, M.D., 28 Crescent Street, Middletown.

1940 WILLIAM M. JOYCE, M.D., 121 Main Street, Middletown.

1942 ROY L. LEAK, M.D., Connecticut State Hospital, Middletown.

1942 DANIEL A. NOLAN, M.D., 613 Main Street, Middletown.

1944 LLOYD W. MINOR, M.D., 119 Main Street, Middletown.

1944 ALFRED N. SWEET, M.D., 70 Crescent Street, Middletown.

1928 LOUIS LABELLA, 612 Main Street, Middletown.  
 Annual Meeting, Second Thursday in April.

Semi-Annual Meeting, Second Thursday in October.

## CHESTER

1935 Lieberman, David Leonard.

## CLINTON

1937 Rindge, Norman Pember, 49 Pearl.

1935 Stone, Harry Russell, 67 West Main.

## CROMWELL

1934 Couch, Frank Hallock, Cromwell Hall.

1934 Couch, Mildred Warden, Cromwell Hall.

1928 Nelson, Walter Nathaniel, P.O. Box 201.

1925 Pierson, Emily Miller, Main.

1938 Prout, Edgar Bacon, Station 18.

## EAST HADDAM

1924 Crook, Joseph Bruce, P.O. Box No. 133.

## MOODUS

1935 Horsefield, Thomas Earl, P. O. Box 40.

## EAST HAMPTON

1936 Gardner, Norman Homer.

1934 Soreff, Louis, 15 Main.

## ESSEX

1903 Bradeen, Frederick Barton, P. O. Box No. 221.

1908 Davis, Charles Clarence, P. O. Box No. 350.

1938 Scott, J. Clifford, 20 West ave.

## HADDAM

1893 Mead, Kate Campbell Hurd.

## MIDDLETOWN

1926 Armstrong, George Gabriel, Connecticut State Hospital.

1933 Beauchemin, Joseph Adelard, Connecticut State Hospital.

1937 Calhoun, Hazen Albert, Jr., 647 Main.

1926 Chase, Carl Clarence, 121 Main.

1938 Colomb, Anna Catherine, Conn. State Hospital.

1936 Colomb, Henry Octave, Connecticut State Hosp.

1928 Compson, Florence Eberly Mentzer, Connecticut State Hosp.

1924 Craig, George Mansfield, 119 Main.

1935 Elliott, George Albert, Connecticut State Hosp.

1912 Fauver, Edgar, 55 Mt. Vernon.

1933 Fekety, Stephen Henry, 675 Main.

1921 Felt, Paul Revere, Connecticut State Hosp.

1900 Fisher, Jessie Weston, 28 Crescent.

1927 Frank, Harry Selig, 144 Washington.

1931 Gissler, Norman Edwin, 164 Court.

1927 Grower, Julius Harry, 164 Court.

1920 Harvey, Carl Clifford, 119 Main.

1935 Haviland, Walter Childs, Connecticut State Hosp.

1924 Holley, Erving, Connecticut State Hosp.

1924 Joyce, William Michael, 121 Main.

1928 LaBella, Louis Oronato, 612 Main.

1920 Leak, Roy Leighton, Connecticut State Hosp.

1925 Loffredo, Louis, 77 Crescent.

1929 Magnano, Joseph, 100 Broad.

1934 Minor, Lloyd Wesley, 119 Main.

1896 Murphy, James, 101 Broad.

1896 Nolan, Daniel Andrew, 613 Main.

1939 Palmieri, Merio Lorenzo, 43 So. Main.

1928 Piasta, Peter Ferdinand, 602 Main.

1889 Potter, Frank Edward, 160 College.

1934 Roccapiore, Benjamin Anthony, 504 Main.

1926 Russmann, Charles, Connecticut State Hosp.

1929 Speight, Harold Edmund, 642 Main.

1924 Sweet, Alfred Norton, 70 Crescent.

1933 Tracy, Frederick Erwin, 120 Pearl.

1919 Van Cor, Chester Arthur, Connecticut State Hosp.

1939 Wadsworth, George Leland, Conn. State Hosp.

1936 Waldman, Jacob Edward, 252 Main.

- 1933 Whiting, Harry St. John, Connecticut State Hosp.  
 1925 Wilder, Ella Annis, 80 S. Main.  
 1922 Wrang, William Emil, 296 Main.

## OLD SAYBROOK

- 1905 Granniss, Irwin, P. O. Box 312.  
 1934 Greenberg, Aaron.

## PORTLAND

- 1933 Schwartz, Philip Edward, 309 Main.  
 1932 Wagner, Carl Phillips, 25 Marlborough st.

## SAYBROOK

## DEEP RIVER

- 1939 Lobb, Russell Albert, 131 Main st.  
 1903 Pratt, Arthur Milton, P. O. Box 477.  
 1932 Tate, William James, Elm.

## WESTBROOK

- 1939 McDermott, Terence Stephen, Horse Hill rd.  
 1939 Sikes, Ralph Fuller, P. O. Box 257.

## OUT OF COUNTY

- 1890 Coleburn, Arthur Burr, 5 Cannon Street, Norwalk.  
 1904 Kingman, James Henry, 96 Everit St., New Haven.  
 1928 Ward, Arthur Henry, Woodside Cottages, Framingham, Mass.  
 1936 Wilcox, Frederick Carpenter, Jr., Brooklyn Hosp., DeKalb ave. and Ashland place, Brooklyn, N.Y.  
 Total number 70

## NEW HAVEN COUNTY

*President*, COLE B. GIBSON, M.D., "Undercliff", Meriden.  
*Vice-President*, J. HAROLD ROOT, M.D., 103 North Main Street, Waterbury.

*Secretary*, RALPH E. McDONNELL, M.D., 158 Whitney Avenue, New Haven.

*Councilor*, THOMAS P. MURDOCK, M.D., 147 West Main Street, Meriden.

*Censors*

(Elected annually)

CHARLES L. LARKIN, M.D., 101 North Main Street, Waterbury.

RAYMOND V. QUINLAN, M.D., 5 State Street, Meriden.

LOUIS H. NAHUM, M.D., 1142 Chapel Street, New Haven.  
 (Committee on Public Policy and Legislation)

(Appointed annually by the President)

CHARLES W. COMFORT, JR., M.D., 27 Elm Street, New Haven.

CHARLES W. GAYLORD, JR., M.D., 93 South Main Street, Branford.

A. NOWELL CREADICK, M.D., 79 Trumbull Street, New Haven.

JAMES D. MCGAUGHEY, M.D., 261 Center Street, Wallingford.

CHARLES L. LARKIN, M.D., 101 North Main Street, Waterbury.

*Committee on Medical Ethics and Deportment*

(Two appointed annually by the President for a term of 3 years)

JOHN S. DYE, M.D., 111 West Main Street, Waterbury.

CHARLES J. BARTLETT, M.D., Grace Hospital, New Haven.

THOMAS P. MURDOCK, M.D., 147 West Main Street, Meriden.

CREIGHTON BARKER, M.D., 258 Church Street, New Haven.

DAVID P. SMITH, M.D., 199 West Main Street, Meriden.

STANHOPE BAYNE-JONES, M.D., 333 Cedar Street, New Haven.

Annual Meeting, Fourth Thursday in April.

Semi-Annual Meeting, Fourth Thursday in October.

## ANSONIA

- 1916 Aaronson, Michael S., 410 Main.  
 1937 Alu, Anthony F., 290 Main.  
 1935 Blumenthal, Edward Jedediah, 88 Main.  
 1938 Casagrande, John J., 178 Main.  
 1915 O'Neil, William Henry, 156 Main.  
 1907 Parmelee, Edward Kibbe, 50 Main.  
 1932 Renehan, John Michael, 100 Main.  
 1924 Senfield, Maxon Major, 110 Main.  
 1924 Steudel, Henry, 88 Main.  
 1924 Thomas, John Joseph, 290 Main.  
 1909 Tolles, Burton Isaac, 38 Main.  
 1900 Wilmot, Louis Howard, 2 S. Cliff.

## BRANFORD

- 1934 Blanchard, Dana Lincoln, 87 Main.  
 1931 Bodie, William Joseph, 146 Montowese.  
 1917 Gaylord, Charles Woodward, 93 S. Main.  
 1929 Levy, Nathan, 94 Main.  
 1916 McQueen, Arthur Samuel, 187 Montowese.

## PINE ORCHARD

- 1919 Smith, George Milton.

## CHESHIRE

- 1926 Lindsay, John Crandall, State Reformatory.  
 1923 Moore, Wilbur John, Maple ave.  
 1939 Oxnard, Edward Warren, Maple ave.

## DERBY

- 1916 Baldwin, Charles Tomlinson, 74 Fourth.  
 1927 Burns, George Dewey, 272 Main.  
 1885 Loomis, Frank Newton, 100 Atwater ave.  
 1910 Parlato, Michael Antonio, 270 Elizabeth.  
 1929 Pepe, Carmen Thomas, 157 Minerva.  
 1890 Pinney, Royal Watson, 116 Derby ave.  
 1914 Plunkett, Thomas Francis, 18 Elizabeth.  
 1925 Rentsch, Samuel Burton, 61 Seymour ave.  
 1927 Scott, William Joseph, 58 Elizabeth.  
 1910 Treat, William Howard, 258 Main.

## EAST HAVEN

- 1924 Taylor, Robert Mitchell, 578 Thompson ave.

## GUILFORD

- 1935 Davis, George Breed, 29 Whitfield.  
 1916 Smith, Frederic DeWitt, 55 Park.

## HAMDEN

- 1937 Case-Downes, Muriel, 95 Wayland.  
 1936 Corey, Walter VanArsdale, 1188 Whitney ave.  
 1926 Ematrudo, Frederick Roys, 1756 Whitney ave.  
 1904 Lay, Walter Sidders, 2320 Whitney ave.  
 1927 Slater, Morris, 1100 Dixwell ave.

## MOUNT CARMEL

- 1890 Joslin, George Herri, 2798 Whitney ave.

## MADISON

- 1929 Hughson, Donald Thomas, Boston Post rd.  
 1908 Rindge, Milo Pember, Boston Post rd.

## MERIDEN

- 1934 Affinito, Thomas, 128 W. Main.  
 1929 Campbell, Sherbourne, 147 W. Main.  
 1928 Caplan, Henry, 27 1/2 W. Main.  
 1939 Caplan, Max, 197 Cooke ave.



- 1937 Carey, William Clark, 61 Colony.  
 1924 Carroll, William Edward, "Undercliff".  
 1937 Cohen, David Jerome, 3 Colony.  
 1926 Conroy, Michael Joseph, 64 1/2 E. Main.  
 1927 DeRosa, Sylvester Frank, 90 W. Main.  
 1930 Foster, Edward Wendell, 147 W. Main.  
 1921 Gibson, Cole Blease, „Undercliff,,.  
 1929 Hall, William Edward, 147 W. Main.  
 1939 L'Heureux, Jerome A., 93 E. Main.  
 1937 Kaschub, Robert William, 119 W. Main.  
 1896 LaPointe, John William Henry, 56 1/2 W. Main.  
 1939 Liebow, Averill Abraham, 12 King.  
 1934 Lirot, Stephen Leo Robert, 28 Crown.  
 1907 Lockwood, Howard DeForest, 248 E. Main.  
 1938 McCullough, Edward A., 53 1/2 West Main.  
 1934 Mekrut, Joseph Anthony, 34 1/2 W. Main.  
 1928 Mills, Bernard Litchfield, 94 E. Main.  
 1934 Misuk, Joseph Francis, 489 Broad.  
 1913 Murdock, Thomas Patrick, 147 W. Main.  
 1921 Otis, Fessenden Newport, 165 W. Main.  
 1920 Otis, Israel Sabine, 165 W. Main.  
 1932 Pennington, Harry Freeman, 455 Broad.  
 1937 Petrucelli, Rocco Joseph, 147 W. Main.  
 1931 Pierson, Louis A., 147 W. Main.  
 1916 Quinlan, Raymond Vincent, Lawton Bldg., 5 State.  
 1913 Smith, David Parker, 199 W. Main.  
 1935 Solomon, Charles Isadore, State School for Boys.  
 1934 Strickland, Harold, 128 W. Main.  
 1921 Tower, Arthur Augustus, 147 W. Main.  
 1936 Van Antwerp, Lee Douglas, "Undercliff".  
 1921 Wilson, James Alfred, 61 Colony.  
 1913 Wilson, Leslie Adams, 232 Colony.
- MILFORD
- 1938 Barney, Walter Edward, 186 Broad.  
 1932 Budau, John Harry Diederichs, 442 E. Broadway,  
 Silver Beach.  
 1913 Fischer, William John Henry, 3 Lafayette.  
 1929 Geib, Henry Albert, Zion Hill rd.  
 1935 Harrington, Albert Eugene, 96 Broad.  
 1932 Heady, Carlton Kellogg, 26 Cherry.  
 1928 Hyde, Clinton John, 63 Gulf.  
 1933 Stetson, Harry Warren, 114 Broad.
- DEVON
- 1934 Andrus, Oliver Burton, 531 Daytona ave.
- NAUGATUCK
- 1922 Duffy, Vincent Paul, 83 Meadow.  
 1923 Hill, William Edward, 150 Meadow.  
 1927 Johnson, Harold Albert, 297 Church.  
 1936 Pine, Clifford Shepard, 14 Hillside ave.  
 1938 Reilly, Walter J., 170 Meadow.  
 1937 Towne, Nehemiah Alvarado, 19 Hillside ave.  
 1926 Williams, Edward Everett, 269 Church.
- UNION CITY
- 1935 Curran, Edwin Russell, 364 N. Main.
- NEW HAVEN
- 1935 Abbey, Edward Augustin, 255 Bradley st.  
 1937 Abrashkin, Mortimer Dick, 1187 Chapel.  
 1921 Alderman, Irving Saunders, 204 Park.  
 1925 Allen, Edward Pratt, 27 Elm.  
 1902 Allen, Millard Filmore, 65 Dixwell ave.  
 1893 Alling, Arthur Nathaniel, 257 Church.  
 1919 Alpert, Reuben Harry, 1142 Chapel.  
 1932 Amatruda, Frank Gabriel, 542 Chapel.  
 1939 Anderson, Clifford Winthrop, 789 Howard ave.  
 1908 Arnold, Harold Sears, 442 Temple.  
 1930 Arnold, Hermann Bruno, 1460 Chapel.  
 1916 Baldwin, William Pitt, 1226 Chapel.  
 1920 Barker, Creighton, 129 Whitney ave.  
 1900 Barnes, William Samuel, 265 Church.  
 1908 Barrett, William Joseph, 546 Chapel.  
 1896 Bartlett, Charles Joseph, 183 Bishop.  
 1936 Bassin, Alexander Lewis, 789 Howard ave.  
 1930 Batelli, Clement Francis, 328 Townsend ave.  
 1925 Battista, Anthony William, 111 Osborn ave.  
 1934 Bayne-Jones, Stanhope, 333 Cedar.  
 1909 Beck, Frederick George, 193 York.  
 1926 Behan, Edmund Joseph, 1370 Chapel.  
 1931 Benedict, Mary Kendrick, 10 Lincoln.  
 1911 Bergman, Axel P., 27 Elm.  
 1920 Berman, Harry Loring, 1142 Chapel.  
 1939 Bishop, Courtney Craig, 158 Whitney ave.  
 1907 Blake, Eugene Maurice, 303 Whitney ave.  
 1922 Blake, Francis Gilman, 789 Howard ave.  
 1927 Blodinger, Israel Edward, 1142 Chapel.  
 1927 Blum, Max, 566 Howard ave.  
 1907 Blumer, George, 158 Whitney ave.  
 1911 Boardman, Albertus Kellogg, 441 Forbes ave.  
 1926 Bodie, John Allen, 221 Columbus ave.  
 1939 Boisvert, Paul Leo, 856 Howard ave.  
 1919 Bonoff, Zelly Adam, 1204 Chapel.  
 1919 Bretzfelder, Karl Benjamin, 265 Church.  
 1935 Brody, Bernard Stephen, 303 Whitney ave.  
 1938 Bruckner, William J., 129 Whitney ave.  
 1930 Bumstead, John Henry, 256 Bradley.  
 1934 Canfield, Norton, 789 Howard ave.  
 1928 Capecelatro, Alfonso, 142 Columbus ave.  
 1916 Carelli, Genesis Frank, 27 Elm.  
 1932 Celentano, Luca Eugene Humbert, 115 Howe.  
 1938 Chasoff, John Arthur, Grace Hospital.  
 1892 Cheney, Benjamin Austin, 265 Church.  
 1934 Claiborn, Louie Nixon, 303 Whitney ave.  
 1937 Clark, Mildred H., 244 Sherman ave.  
 1938 Clarke, Clement Cobb, 158 Whitney ave.  
 1935 Climo, Samuel, 1172 Chapel.  
 1923 Cobey James Francis, 1210 Chapel.  
 1922 Coffey, James Ryle, 216 Grand ave.  
 1925 Cofrances, Louis William, 190 Winthrop ave.  
 1901 Cohane, Jeremiah Joseph, 59 College.  
 1904 Cohane, Timothy Francis, 400 Congress ave.  
 1924 Cohen, William, 1195 Chapel.  
 1917 Collins, William Francis, 66 Trumbull.  
 1921 Colwell, Howard Spencer, 129 Whitney ave.  
 1914 Comfort, Charles Williams, Jr., 27 Elm.  
 1931 Connolly, Arthur James, 59 Trumbull.  
 1914 Conte, Harry Albert, 5 Elm.  
 1921 Cook, Robert Jay, 85 Whitney ave.  
 1931 Corradino, Charles Louis, 516 Howard ave.  
 1921 Creadick, Abraham Nowell, 79 Trumbull.  
 1936 Culotta, Charles Salvatore, 388 Orange.  
 1934 Cushing, Harvey, 789 Howard ave.  
 1924 Dallas, Marion, 248 Bradley.  
 1935 D'Amico, Michael, 303 Whitney ave.  
 1934 Darrow, Daniel Cady, 789 Howard ave.  
 1939 Davis, Jachin Boaz, 158 Whitney ave.

- 1920 Dayton, Arthur Bliss, 129 Whitney ave.  
 1920 Deming, Charles Kenneth, 257 Church.  
 1922 Deming, Clyde Leroy, 789 Howard ave.  
 1925 Dennehy, William James, 1282 State.  
 1908 Diefendorf, Allen Ross, 121 Whitney ave.  
 1938 Dobbs, William G. H., 1418 Chapel.  
 1922 Duffy, William Core, 55 Trumbull.  
 1939 Edwards, Gwilym Austin, 789 Howard ave.  
 1923 Errico, Louis, 26 Elm.  
 1925 Evans, Theodore Schlosser, 59 Trumbull.  
 1935 Fenney, Philip William, 705 Dixwell ave.  
 1913 Ferguson, Robert John, 59 College.  
 1929 Fiskio, Peter William, 307 Humphrey.  
 1937 FitzSimons, Edmund Francis, 589 Howard ave.  
 1914 Flynn, Charles Thomas, 41 Trumbull.  
 1917 Flynn, David Aloysius, 326 Grand ave.  
 1929 Flynn, Harold Aloysius, 464 Dixwell ave.  
 1888 Foote, Charles Jenkins, 257 Church.  
 1929 Foster, Lewis Chandler, 256 Bradley.  
 1925 Fox, James Charles, Jr., 789 Howard ave.  
 1924 Freedman, Barnett Philip, 322 George.  
 1936 Freeman, David, 405 Temple.  
 1937 Fry, Clements Collard, 109 College.  
 1938 Geiger, Arthur Joseph, 789 Howard ave.  
 1939 Gendel, Benjamin Robert, 113 Sherman ave.  
 1937 Gentile, Angelo Louis, 601 Chapel.  
 1920 Geraci, Lucian Arthur, 546 Chapel.  
 1937 German, William John, New Haven Hosp.  
 1923 Gettings, James Augustus, 209 Whalley ave.  
 1924 Giamarino, Henry James, 532 Chapel.  
 1923 Giannotti, Carl Charles, 214 Lafayette.  
 1926 Glazer, Morris, 1204 Chapel.  
 1910 Goldberg, Samuel James, 43 Trumbull.  
 1912 Goldman, George, 201 Park.  
 1927 Goldstein, Morris, 451 George.  
 1935 Goldstein, Richard Moses, 333 Cedar.  
 1938 Goodman, Louis S., 333 Cedar.  
 1924 Greenhouse, Barnett, 107 Whitney ave.  
 1927 Groark, Joseph Anthony, 145 Grand ave.  
 1931 Grodin, Herman Wolmer, 840 Howard ave.  
 1936 Hankin, Morris Albert, 43 Trumbull.  
 1930 Harris, Benedict Richard, 176 Dwight.  
 1937 Harris, Jesse Samuel, 176 Dwight.  
 1931 Harrison, Elizabeth Ross, 255 Bradley.  
 1935 Hart, James Clement, 820 Elm.  
 1939 Hartman, Frederick Bittinger, 789 Howard ave.  
 1903 Hartshorn, Willis Ellis, 67 Trumbull.  
 1920 Harvey, Samuel Clark, 789 Howard ave.  
 1937 Hathaway, John Seabury, 109 College.  
 1916 Hendricks, Albert Ludwig, 26 Trumbull.  
 1907 Henze, Carl William, 466 Orange.  
 1925 Herrmann, Julian Bertram, 204 Park.  
 1937 Hess, Orvan Walter, 79 Trumbull.  
 1908 Hessler, Herman Philip, 370 Livingston.  
 1930 Higgins, Joseph John, 48 Dwight.  
 1922 Hillman, Maurice Manuel, 1249 Chapel.  
 1927 Hippolitus, Jean DeFrancis, 1447 Chapel.  
 1916 Hirata, Isao, 1455 Chapel.  
 1924 Howard, Albert Joseph, 432 Whalley ave.  
 1935 Howard, Marion Edith, 789 Howard ave.  
 1915 Hynes, Frederick Henry, 195 Church.  
 1903 Hynes, Thomas Vincent, 1441 Chapel.  
 1914 Jack, Gabriel Joseph, 347 Orange.  
 1924 Jack, John Louis, 412 Orange.  
 1936 Jackson, Edith Banfield, 333 Cedar.  
 1914 James, George Richard, 195 Church.  
 1927 Jenkins, Ralph Hathaway, 59 College.  
 1933 Johnson, Carl Edward, 158 Whitney ave.  
 1919 Johnson, Edgar Mayer, 73 Howe.  
 1938 Jordan, Robert Hough, 59 Trumbull.  
 1937 Kahn, Eugen, 333 Cedar.  
 1932 Kaplowe, Joseph Louis, 201 Park.  
 1938 Kennard, Margaret A., 333 Cedar.  
 1901 Kilbourn, Clarence Leishman, 202 Blatchley ave.  
 1938 Klatskin, Gerald, 255 Bradley.  
 1928 Klebanoff, Harry Erwin, 1497 Chapel.  
 1917 Kleiner, Simon Bretzfelder, 41 Trumbull.  
 1938 Klinghoffer, Kalmen Anselm, 789 Howard ave.  
 1935 Krosnick, Morris Yale, 1195 Chapel.  
 1935 Kuh, Clifford, 31 Howe.  
 1937 Kushlan, Samuel Daniel, 303 Whitney ave.  
 1936 Laviates, Paul Harold, 789 Howard ave.  
 1915 Lear, Maxwell, 1172 Chapel.  
 1935 Leddy, Percy Allen, 109 College.  
 1938 Leonard, John Charles, 789 Howard ave.  
 1923 Levin, Hyman Alexander, 1142 Chapel.  
 1920 Levy, Daniel Frederick, 5 College.  
 1905 Lewis, Dwight Milton, 169 Church.  
 1923 Lewis, Robert Morton, 52 Trumbull.  
 1911 Linde, Joseph Irving, City Hall.  
 1927 Lindsay, Merrill Kirk, 434 Temple.  
 1934 Linskog, Gustaf Elmer, 789 Howard ave.  
 1919 Little, Herman Clark, 303 Whitney ave.  
 1927 Logan, William Joseph, 412 Whalley ave.  
 1905 Ludington, Nelson Amos, 1252 Chapel.  
 1926 MacCready, Paul Beattie, 442 Temple.  
 1937 MacNish, J. Francis, 45 Trumbull.  
 1900 Maher, James Stephen, 261 Orange.  
 1878 Mailhouse, Max, 195 Church.  
 1927 Marshall, Carter Lee, 198 Dixwell ave.  
 1928 Marvin, Harold Myers, 303 Whitney ave.  
 1921 Massa, Anthony Francis, 697 Elm.  
 1931 Mastorianni, Luigi, 248 Bradley.  
 1925 Maurer, Lloyd Leslie, 41 Trumbull.  
 1920 Maynard, Harry Hilts, 882 Howard ave.  
 1934 McAlenney, Paul Francis, Jr., 79 Trumbull.  
 1922 McDonnell, Ralph Edward, 158 Whitney ave.  
 1913 McGuire, William Charles, 104 Park.  
 1899 McIntosh, Edward Francis, 307 Alden ave.  
 1916 Mendillo, Anthony Joseph, 45 Trumbull.  
 1933 Mendillo, John Carleton Francis, 255 Bradley st.  
 1938 Mignone, Joseph, 388 Orange.  
 1930 Mongillo, Frank, 5 Elm.  
 1916 Morse, Arthur Henry, 789 Howard ave.  
 1938 Mucci, Lawrence Adolf, 789 Howard ave.  
 1922 Musselman, Luther Kyner, 215 Whitney ave.  
 1921 Nahum, Louis Herman, 1142 Chapel.  
 1922 Newman, Joseph Thomas, 150 Shelton ave.  
 1914 Nichols, Ralph Wilbur, 57 Trumbull.  
 1932 Nodelman, Jacob, 20 Elm.  
 1933 O'Brasky, Louis, 1172 Chapel.  
 1920 O'Brien, William Henry Joseph, 265 Church.  
 1922 O'Connor, Denis Stanislaus, 158 Whitney ave.  
 1885 Osborne, Oliver Thomas, 1155 Forest rd.



- 1931 Oughterson, Ashley Webster, 789 Howard ave.  
 1936 Palmieri, Michael Walter, 551 Howard ave.  
 1938 Parente, Leonard, 64 Trumbull.  
 1929 Paul, John Rodman, 789 Howard ave.  
 1894 Peck, Robert Ellsworth, 1418 Chapel.  
 1922 Perrins, Harlan Bassett, 59 Trumbull.  
 1925 Peters, John Punnett, 789 Howard ave.  
 1927 Petrelli, Joseph, 455 Orange.  
 1923 Philipson, Samuel, 61 Park.  
 1909 Phillips, Frank Lyman, 405 Temple.  
 1935 Piazza, George Joseph, 78 Orchard.  
 1931 Pinn, Abraham Samuel, 75 Sherman ave.  
 1927 Poole, Allan King, 442 Temple.  
 1916 Porter, Donald Wallace, 58 Trumbull.  
 1938 Poverman, Abraham D., 57 Trumbull.  
 1927 Powell, Wilson, 1266 Forest rd.  
 1925 Powers, Grover Francis, 789 Howard ave.  
 1934 Rademacher, Everett Stanley, 442 Temple.  
 1903 Rand, Richard Foster, 246 Church.  
 1903 Reilly, Francis Henry, 230 Church.  
 1924 Riccitelli, Mariano Louis, 476 Howard ave.  
 1937 Robbins, Clarence Loveridge, 158 Whitney ave.  
 1929 Roberts, Frederick William, 129 Whitney ave.  
 1920 Rogers, Orville Forrest, 109 College.  
 1929 Rogowski, Bernhard Albert, 75 Whitney ave.  
 1932 Rothschild, Morris Loeb, 265 Church.  
 1937 Rubin, George Alan, 1150 Chapel.  
 1914 Russell, Thomas Hubbard, 57 Trumbull.  
 1922 Russell, Walter Irving, 317 Whalley ave.  
 1920 Russo, Joseph Daniel, 120 Blatchley ave.  
 1921 Ryder, William Harold, 195 Church.  
 1933 Salinger, Robert, 256 Bradley.  
 1910 Sanford, Charles Edwin, 265 Church.  
 1939 Savarese, Melchior F. R., 41 Howe.  
 1911 Scarbrough, Marvin McRae, 47 Trumbull.  
 1931 Scholl, Robert Frederick, 215 Whitney ave.  
 1924 Scott, Clifton Russell, 215 Whitney ave.  
 1920 Seabury, Robert Brewster, 64 Trumbull.  
 1916 Segnalla, Ernest, 613 Chapel.  
 1923 Serafin, Peter James, 809 State.  
 1928 Shay, Francis Leo, 368 Alden ave.  
 1923 Shea, Michael Stephen, 500 Howard ave.  
 1915 Sheahan, William Lawrence, 59 College.  
 1929 Shure, Abraham Lewis, 85 Whitney ave.  
 1923 Silverberg, Samuel Joshua, 201 Park.  
 1913 Skiff, Stuart Ernest, 1194 Chapel.  
 1923 Smith, Charles Seaver, 59 College.  
 1914 Smith, Marvin, 356 Humphrey.  
 1926 Smith, Norman Nathaniel, 1558 Chapel.  
 1927 Snurkowski, Charles Vincent, 487 Orange.  
 1938 Speir, Edward B., 789 Howard ave.  
 1927 Sperandeo, Anthony, 538 Chapel.  
 1896 Sperry, Frederick Noyes, 85 Whitney ave.  
 1907 Standish, Frank Billings, 193 York.  
 1936 Stevens, Marvin Allen, 256 Bradley.  
 1916 Stewart, Harry Eaton, 262 Bradley.  
 1925 Stone, Emerson Law, 129 Whitney ave.  
 1920 Strauss, Maurice Jacob, 41 Trumbull.  
 1897 Sullivan, John Francis, 1346 Chapel.  
 1923 Sullivan, Thomas Joseph, 495 Orange.  
 1886 Swain, Henry Lawrence, 195 Church.  
 1914 Sweet, Grover Cleveland, 1537 Chapel.  
 1921 Sword, Brian Collins, 16 Dwight.  
 1921 Tanner, Monroe Julius, 26 High.  
 1938 Thompson, Kenneth W., 789 Howard ave.  
 1936 Thompson, Lloyd James, 333 Cedar.  
 1915 Thoms, Herbert, 789 Howard ave.  
 1911 Tileston, Wilder, 442 Temple.  
 1922 Toole, Frank Edward, 419 Whalley ave.  
 1909 Townshend, Raynham, 57 Trumbull.  
 1911 Tracy, Robert Graham, 493 Howard ave.  
 1925 Trask, James Dowling, 789 Howard ave.  
 1923 Tyler, Margaret, 158 Whitney ave.  
 1896 Verdi, William Francis, 27 Elm.  
 1924 Vestal, Paul William, 79 Trumbull.  
 1926 Wakeman, Edward Taylor, 129 Whitney ave.  
 1919 Weil, Arthur, 85 Whitney ave.  
 1924 Weiner, Joseph, 1172 Chapel.  
 1902 Welch, Harry Little, 59 College.  
 1907 Wheatley, Louis Frederick, 61 Trumbull.  
 1916 Whiting, Leonard Clark, 121 Whitney ave.  
 1906 Whittemore, Edward Reed, 33 Whitney ave.  
 1936 Wies, Frederick Albert, 255 Bradley.  
 1931 Willner, Otto, 61 Trumbull.  
 1935 Wilson, Hugh Monroe, 789 Howard ave.  
 1927 Wilson, Louise Whitman Farnam, 616 Prospect.  
 1931 Wilson, William Rives, 58 Trumbull.  
 1939 Winkler, Alexander Woodward, 789 Howard ave.  
 1899 Winne, William Nelson, 1020 Whalley ave.  
 1921 Winternitz, Milton Charles, 310 Cedar.  
 1922 Winters, Sidney, 1175 Chapel.  
 1895 Wurtenburg, William Charles, 445 St. Ronan.  
 1935 Yannet, Herman, 789 Howard ave.  
 1924 Yavis, John Constantine, 115 Dwight.  
 1920 Yudkin, Arthur Meyer, 257 Church.  
 1933 Zimmerman, Harry Martin, 310 Cedar.
- NORTH HAVEN
- 1913 Lang, William P., "The Cedars".  
 1934 Minitier, John Joseph, Broadway.  
 1923 Taylor, Sterling Price, Broadway and Post rd.
- SEYMOUR
- 1938 Chobian, Joseph A., 159 Main.  
 1934 Rogol, Oscar, 135 Main.
- WALLINGFORD
- 1935 Boyarsky, Harry Morton, 60 Center.  
 1932 Breck, Charles Arthur, 176 N. Main.  
 1908 Buffum, John Harold, 145 N. Main.  
 1930 Carrozzella, John Christy, 50 S. Main.  
 1905 Lyman, David Russell, Gaylord Farm Sanatorium.  
 1911 McGaughey, James David, 261 Center.  
 1916 Morriss, William Haviland, Gaylord Farm Sanatorium.  
 1936 Murphy, Thomas Basil, 342 Center.  
 1925 Riordan, William James, 261 Center.  
 1919 Sheehan, Mark Thomas, 1 Williams.  
 1933 Wilson, George Campbell, Gaylord Farm Sanatorium.
- WATERBURY
- 1924 Allen, Harry Everett, 30 Prospect.  
 1929 Atkins, Samuel Maurice, 63 Central ave.  
 1923 Audet, Charles Henry, 95 N. Main.  
 1910 Barber, Walter Lewis, Jr., 87 N. Main.  
 1937 Berman, Bernard Alfred, 161 N. Main.  
 1908 Bevens, Theodore Frank, 111 W. Main.

1931 Bizzozero, Orpheus Joseph, 20 Grove.  
 1922 Boardman, Emma Irene, R. F. D. No. 2.  
 1910 Brennan, Patrick Joseph, 135 W. Main.  
 1928 Brown, Abe Solomon, 58 Central ave.  
 1894 Brown, Charles Henry, 57 N. Main.  
 1927 Ciminera, Joseph Anthony, 202 Bank.  
 1935 Collins, Joseph Osborn, Waterbury Hospital.  
 1932 Corbett, Herbert John, 14 Central ave.  
 1928 Cottiero, Thomas, 21 Cooke.  
 1907 Cowan, Isabella, 79 N. Main.  
 1907 Deming, Dudley Brainard, 67 Willow.  
 1912 Dillon, John Henry, 325 E. Main.  
 1927 Dreher, Alfred Charles, 171 N. Main.  
 1902 Dwyer, Patrick James, 95 N. Main.  
 1917 Dye, John Sinclair, 111 W. Main.  
 1927 Edlin, Charles, 24 Central ave.  
 1916 Egan, John Joseph, 83 Willow.  
 1905 Engelke, Charles, 24 Central ave.  
 1922 Fabricant, Samuel Elmer, 9 Cooke.  
 1905 Farrell, John Edward, 21 Holmes ave.  
 1937 Finkelstein, William, 103 N. Main.  
 1926 Finn, Alred Joseph, 164 W. Main.  
 1926 Fitzpatrick, Edward Earl, 83 E. Main.  
 1927 Foster, John Hess, 77 N. Main.  
 1928 Freiheit, John Martin, 85 Grove.  
 1937 Fruin, John William, 76 Center.  
 1909 Gancher, Jacob, 275 N. Main.  
 1923 Godfrey, Edward John, 135 W. Main.  
 1914 Good, William Murray, 63 Center.  
 1894 Goodenough, Edward Winchester, City Hall.  
 1915 Green, Jacques Henry, 171 N. Main.  
 1923 Hackett, John Francis, 154 Grand.  
 1933 Harvey, Joseph LeRoy, 222 Ledgeside ave.  
 1911 Herr, Edward Albert, 43 Central ave.  
 1930 Herrmann, Albert Edward, 101 N. Main.  
 1931 Hetzel, Joseph Linn, 103 N. Main.  
 1934 Hill, Frank Joseph, 863 Bank.  
 1919 Jackson, Andrew Joseph, 20 E. Main.  
 1929 Jackson, Edward Joseph, 76 Center.  
 1939 Jennes, Sidney Weinberg, 29 Leavenworth.  
 1922 Johnson, Arthur August, 59 Central ave.  
 1915 Johnston, Ernest Hillock, 18 Savings.  
 1914 Kirschbaum, Edward Harry, 20 Grove.  
 1922 Larkin, Charles Lewis, 101 N. Main.  
 1910 Lawlor, Michael Joseph, 158 N. Main.  
 1907 Leonard, George Arthur, 79 N. Main.  
 1924 Lombardi, Pasquale Frederick, 46 Prospect.  
 1897 Maloney, Daniel Joseph, 79 N. Main.  
 1939 Margolius, Norman Calvin, 125 Grove.  
 1922 Martin, James Smith, 135 W. Main.  
 1930 Mason, Broadstreet Henry, Waterbury Hosp.  
 1916 McGrath, John Henry, 309 E. Main.  
 1906 McLarney, Thomas Joseph, 27 Cherry.  
 1925 Merriman, Merritt Heminway, 115 Prospect.  
 1897 Moriarty, James Ligouri, 52 Holmes ave.  
 1928 Morrill, Harold Frost, 300 W. Main.  
 1928 Mueller, Richard Albert, 287 N. Main.  
 1932 Mullen, John Joseph, 135 W. Main.  
 1929 Neuswanger, Chris Harold, 89 N. Main.  
 1937 Parker, Thomas E., 416 S. Main.  
 1923 Platt, Irving Smith, 77 N. Main.  
 1901 Pomeroy, Nelson Asa, 96 Hillside ave.

1931 Pyle, Edwin, 95 N. Main.  
 1916 Quinn, Raymond James, 730 Baldwin.  
 1920 Root, James Harold, 103 N. Main.  
 1925 Ruby, Max Harold, 47 Prospect.  
 1939 Ruby, Robert J., 47 Prospect.  
 1914 Ryder, Raymond Harrison, 52 Central ave.  
 1931 Sandulli, Gaetano Renato, 347 N. Main.  
 1928 Santoro, Grace Marie, 95 N. Main.  
 1939 Sayers, Daniel O'Connell, 278 East.  
 1933 Shea, Vincent Timothy, 20 E. Main.  
 1935 Slavin, Joseph E., 798 E. Main.  
 1906 Smith, Egbert Livingston, 292 W. Main.  
 1929 Smith, Goodrich Truman, 30 W. Main.  
 1915 Spicer, Edmund, 292 W. Main.  
 1931 Staneslow, John Stanislovaitis, 95 N. Main.  
 1924 Stettbacher, Henry John, 28 Prospect.  
 1906 Swenson, Andrew Clay, 43 Central ave.  
 1916 Vastola, Anthony P., 103 N. Main.  
 1920 Webber, Edwin Russell, 95 N. Main.

## WEST HAVEN

1929 Appell, Harold Seymour, 354 Campbell ave.  
 1935 D'Esopo, Joseph Nicholas, W. W. Winchester Hosp.  
 1909 Gilmore, Joseph Leo, 336 Main.  
 1904 Kowalewski, Victor Alexander, 597 Campbell ave.  
 1930 Milano, Nicola Antonio, 271 Elm.  
 1923 O'Connell, William Michael, 295 Main.  
 1915 Rogers, Platt Harrison, 228 Elm.  
 1933 Snavelly, Marion Elizabeth, 546 Washington ave.  
 1928 Soper, Willard Burr, W. W. Winchester Hosp.

## OUT OF COUNTY

1935 Bell, Jerry Sheridan, 39 Prospect pl., Brooklyn, N. Y.  
 1935 Bergin, Edward P., 1760 Crosby ave. Bronx.  
 1931 Dryfus, Milton Leopold, 130 W. 57th st., N. Y. C.  
 1921 Dunham, Ethel Collins, 3312 N st., N. W., Washington, D. C.  
 1937 Eliot, Martha May, 1815 45th N. W., Washington, D. C.  
 1933 Emery, Edgar VanNorman, 7390 Norwood ave., St. Louis, Mo.  
 1934 Ferguson, John Archibald, 63 Robinson ct., Burlington, Vt.  
 1892 Ferris, Harry Burr, 368 Bahia Vista ave., Sarasota, Fla. (Oct.-May): Clinton (May-Oct.).  
 1933 Gordon, Ernest Foster, 27 Ludlow st., Yonkers, N. Y.  
 1923 Garcia, Alphonso G., Moosup.  
 1896 Graves, Frederick George, Bethlehem.  
 1921 Greenway, James Cowan, Meads pt., Greenwich.  
 1931 Hennessy, James Joseph, Cedarcrest San., Hartford.  
 1936 Klumpp, Theodore George, Dept. of Agriculture, Food and Drug Admin., Washington, D. C.  
 1932 MacDonald, John Joseph, 348 Ogden st., Jersey City, N. J.  
 1917 Merrill, William Truman, 66 Fuller lane, East Milton, Mass.  
 1929 Russell, Ernest Frederick, Riven Rock, Santa Barbara, Cal.  
 1891 Skinner, Clarence Edward, 51 Madison ave., New York City.



- 1931 Sullivan, Albert Joseph, 3413 Texas ave., S. E.  
Washington, D. C.  
1900 Teele, Julia Ernestine, Box 31, Hall-Brooke San.,  
Greens Farms, Conn.  
1924 Whiteside, George Shattuck, 1212 Fifth ave., New  
York City.

Total number 517

#### NEW LONDON COUNTY

- President*, EDMUND L. DOUGLAS, M.D., 188 Thames Street,  
Groton.  
*Vice-President*, CLARENCE G. THOMPSON, M.D., 257 Main  
Street, Norwich.  
*Secretary*, CARL H. WIES, M.D., 58 Huntington Street,  
New London.  
*Councilor*, GEORGE H. GILDERSLEEVE, M.D., 310 Main  
Street, Norwich.

#### Censors

(One elected annually for a term of three years)

- 1937 THOMAS J. MURRAY, M.D., 34 Huntington Street,  
New London.  
1938 JAMES J. DONOHUE, M.D., 43 Broadway, Norwich.  
1939 RICHARD M. STARR, 45 Huntington Street, New  
London.

#### *Committee on Public Policy and Legislation*

(Appointed annually by the President)

- CHARLES J. SATTI, M.D., 36 Huntington Street, New  
London, *Chairman*.

- LOUIS M. ALLYN, M.D., 22 Library Street, Mystic.

- HAROLD A. BERGENDAHL, 1 Second Avenue, Taftville.

#### *Committee on Medical Ethics and Deportment*

(One appointed annually by the President

for a term of 5 years)

- THOMAS SOLTZ, 26 Main Street, New London.

- THURMAN P. MAINE, M.D., 64 Washington Street, Mystic,  
(1 year).

- LEONE F. LAPIERRE, M.D., 287 Main Street, Norwich,  
(2 years).

- DANIEL SULLIVAN, M.D., 58 Huntington Street, New  
London, (3 years).

- EDMUND L. DOUGLASS, M.D., 188 Thames Street, Groton,  
(4 years).

Annual Meeting, First Thursday in April.

Semi-Annual Meeting, First Thursday in October.

#### COLCHESTER

- 1935 Friedman, Irving, 15 Hayward ave.

- 1921 Pendleton, Cyrus Edmund.

#### EAST LYME

#### NIANTIC

- 1906 Atkinson, Edward, Main.

- 1934 MacLeod, Edith Alice, State Farm for Women.

- 1936 Ward, Lawrence Shapiro.

#### GRISWOLD

#### JEWETT CITY

- 1937 Ansell, Harvey Berle, 30 N. Main.

- 1937 Barry, Joseph Charles.

- 1916 McLaughlin, John Henry, 37 Main.

- 1934 O'Neill, Martin Leo, 8 Park sq.

#### GROTON

- 1916 Barnum, Charles Gardiner, 230 Thames.

- 1918 Douglass, Edmund Latham, 188 Thames.

- 1934 Hewes, Carlisle Tyson, 242 Thames.

- 1937 Lund, Frederic Albert, 213 Shore ave.

- 1914 Smail, Martin Lawson.

#### NOANK

- 1928 Hill, E. Roland.

#### LEDYARD

#### GALE'S FERRY

- 1937 Moore, Maurice R.

#### LYME

- 1927 Ely, Julian Griffin.

#### HADLYME

- 1924 Raynolds, Randolph.

#### MONTVILLE

#### UNCASVILLE

- 1936 Lubchansky, Jacob Harris.

- 1929 Rasmussen, Hans Norman.

#### NEW LONDON

- 1933 Baron, Shirley Harold, 309 State.

- 1933 Becker, Joseph, 325 State.

- 1928 Blank, Eric Henry, 240 Williams.

- 1933 Brosnan, John Francis, 34 Huntington.

- 1927 Burdsall, Elijah Sylvester, 187 Williams.

- 1937 Cantrell, Roy Foster, U. S. Submarine Base.

- 1916 Cheney, George Philip, 179 Montauk ave.

- 1936 Comstock, Edward Richard, 106 State.

- 1938 DeAngelis, Louis, 252 Montauk ave.

- 1909 Dunn, Frank Martin, 100 State.

- 1931 Dyer, Charles Edward, 102 Montauk ave.

- 1936 Ferguson, Helen Knox, 508 Montauk ave.

- 1906 Ganey, Joseph Matthew, 205 Williams.

- 1934 Gipstein, Edward, 58 Huntington.

- 1922 Hendel, Isidor, 50 State.

- 1902 Henkle, Emanuel Alex, 51 Federal.

- 1934 Henkle, Robert Theodore, 51 Federal.

- 1895 Heyer, Harold Hankinson, 70 Colt.

- 1936 Itzkowitz, Hyman, 325 State.

- 1921 Kaufman, Charles, 308 State.

- 1924 Labensky, Alfred, 85 Federal.

- 1909 Lawson, Stuart Johnston, 116 Federal.

- 1921 Lena, Hugh Francis, 154 Broad.

- 1931 Loiacono, Anthony Joseph, 325 State.

- 1934 Morse, Willard Jackson, 32 Channing.

- 1921 Murray, Thomas J., 34 Huntington.

- 1932 Rabinovitch, Alec., 309 State.

- 1936 Rapp, Albert Grant, 325 State.

- 1929 Satti, Charles John, 36 Huntington.

- 1933 Scoville, Dorothea Haven, 40 Channing.

- 1921 Soltz, Thomas, 26 Main.

- 1929 Starr, Richard Mallory, 45 Huntington.

- 1904 Sullivan, Daniel, 58 Huntington.

- 1899 Taylor, John Clifton, 159 State.

- 1933 Taylor, Robert Nelson, 159 State.

- 1925 Warren, Hill Freeman, 100 State.

- 1922 Wellington, Harold Wentworth, 309 State.

- 1935 Wies, Carl Hendricks, 58 Huntington.

- 1913 Wilson, Frank Emery, 302 State.

- 1920 Woodruff, Thomas Adams, 44 Mott ave.

- 1938 Woodward, Joseph Cutler, 41 Huntington.

#### NORWICH

- 1910 Agnew, Robert Robertson, 257 Main.

- 1908 Brophy, Edward Joseph, 10 Shetucket.

- 1916 Callahan, John William, 308 Main.  
 1915 Campbell, Hugh Baird, "Uncas-on-Thames".  
 1935 Carr, Vanderveer Tabor, State Hospital.  
 1934 Carson, Robert James, State Hospital.  
 1925 Dixon, Henry Campbell, 16 Franklin.  
 1916 Driscoll, William Thomas, 257 Main.  
 1916 Freeman, Albert Clark, 54 Broadway.  
 1898 Gildersleeve, Charles Child, 310 Main.  
 1927 Gildersleeve, George Harold, 310 Main.  
 1935 Hale, Virginia Anne, State Hospital.  
 1935 Higgins, Harold William, 257 Main.  
 1898 Higgins, Harry Eugene, 257 Main.  
 1938 Kettle, Ronald Harry, Norwich State Hospital.  
 1914 LaPierre, Arnaud Julian, 287 Main.  
 1907 LaPierre, Leone Franklin, 287 Main.  
 1935 Lukoski, Walter Anthony Francis, 16 Franklin.  
 1936 Mahoney, Joseph John, 105 Main.  
 1922 Manwaring, Ier Jay, Disco bldg.  
 1922 Markoff, Kopland Karl, 16 Franklin.  
 1934 Morse, Lyman Roger, "Uncas-on-Thames".  
 1935 Neumann, Virgil Frank, "Uncas-on-Thames".  
 1935 O'Connell, Patrick Henry, 287 Main.  
 1933 Ogden, Arthur White, State Hospital.  
 1936 Osgood, Charles, 257 Main.  
 1934 Quintiliani, Albert, 43 Broadway.  
 1930 Raymer, John George, 40 Shetucket.  
 1930 Ricksher, Charles, State Hospital.  
 1936 Riendeau, Pauline Laure, P. O. Box 476.  
 1935 Sears, Lewis, 257 Main.  
 1938 Segel, Salam, 257 Main.  
 1929 Suplicki, John William, 255 Main.  
 1921 Sussler, David, 65 Main.  
 1925 Thompson, Clarence George, 257 Main.  
 1938 Tombari, Seraphino Paul, 317 Main.  
 1931 Urquhart, Robert Glen, "Uncas-on-Thames".  
 1934 Waterman, Chester, State Hospital.  
 1935 Weidman, William Harold, "Uncas-on-Thames".  
 1932 Wener, William Victor, 130 Main.  
 1933 Whitty, Charles Aloysius, "Uncas-on-Thames".

## TAFTVILLE

- 1933 Archambault, Henry Allard, 2 N. Second ave.  
 1935 Bergendahl, Harold Andrew, 1 S. Second ave.

## OLD LYME

## BLACK HALL

- 1909 Devitt, Ellis King.

## STONINGTON

- 1934 Haliday, Earle George, 168 Water.  
 1934 Veal, William Thomas, 99 Water.  
 1912 \*Williams, Charles Mallory, 174 Water.

## MYSTIC

- 1907 Allyn, Louis Maxson, 22 Library.  
 1894 Gray, William Henry, 27 Willow.  
 1907 Harrington, James Leon, 27 Grove.  
 1932 Leon, Abraham Joseph, 31 New London rd.  
 1915 Maine, Thurman Park, 64 Washington.

## WATERFORD

- 1913 O'Brien, John Francis, "The Seaside".  
 1931 Thompson, Lawrence Everett, "The Seaside".

## OUT OF COUNTY

- 1932 Griswold, Matthew, 166 Linden st., New Haven.  
 1935 D'Elia, Arthur J., So. Chatham, Mass.

- 1935 Ludlow, Groeg Craig, 8 Oenoke ave., New Canaan.  
 1937 Lund, Frederick Albert.

Total number 119

## TOLLAND COUNTY

*President*, ALFRED SCHIAVETTI, M.D., 107 Main Street, Stafford Springs.

*Vice-President*, HENRY L. CLOW, M.D., Mansfield State Training School and Hospital, Mansfield Depot.

*Secretary*, FRANCIS H. BURKE, M.D., 27 Park Street, Rockville.

*Councilor*, CHARLES T. LAMOURE, M.D., Mansfield State Training School and Hospital, Mansfield Depot.

## Censors

(One elected annually for a term of three years)

FRANCIS M. DICKINSON, M.D., 38 Elm Street, Rockville,  
*Chairman*.

ELLIOTT H. METCALF, M.D., 50 Elm Street, Rockville.

JOHN M. GIVENS, M.D., 54 East Main Street, Stafford Springs.

*Committee on Public Policy and Legislation*

(Appointed annually by the President)

FRANCIS H. BURKE, M.D., 27 Park Street, Rockville,  
*Chairman*.

ROY C. FERGUSON, M.D., 57 Union Street, Rockville.

HARRY H. MOORE, M.D., 46 East Main Street, Stafford Springs.

*Committee on Medical Ethics and Deportment*

(Councilor and one appointed annually by the President for a term of five years)

CHARLES T. LAMOURE, M.D., Mansfield State Training School, Mansfield Depot, *Councilor*.

ELLIOTT H. METCALF, M.D., 50 Elm Street, Rockville,  
*Chairman*.

FRANCIS McL. DICKINSON, M.D., 38 Elm Street, Rockville.

RALPH B. THAYER, M.D., Main Street, Somers.

WILLIAM SCHNEIDER, M.D., 34 Union Street, Rockville.

FRANK B. CONVERSE, M.D., West Willington.

FRANCIS H. BURKE, M.D., 27 Park Street, Rockville,  
*Recorder*.

Annual Meeting, Third Tuesday in April.

Semi-Annual Meeting Third Tuesday in October.

## COVENTRY

## SOUTH COVENTRY

- 1891 Higgins, William Lincoln.

## MANSFIELD

## MANSFIELD DEPOT

- 1934 Clow, Henry Leon, State Training School and Hospital.

- 1934 Fenimore, Benjamin Bertram, State Training School and Hospital.

- 1930 Hankins, Melissa Millner, State Training School and Hospital.

- 1918 LaMoure, Charles TenEyck, State Training School and Hospital.

## SOMERS

- 1921 Thayer, Ralph Bruce, Main.

## STAFFORD

## STAFFORD SPRINGS

- 1928 Bard, George Percival, 53 E. Main.



- 1934 Givens, John McClure, 54 E. Main.  
 1908 Hanley, John Patrick, 15 Church.  
 1921 Moore, Harry, 46 E. Main.  
 1935 Schiavetti, Alfred, 107 Main.

VERNON  
 ROCKVILLE

- 1937 Beckwith, Donald Macfarlane, Prospect at N. Park.  
 1933 Burke, Francis Henry, 27 Park.  
 1908 Dickinson, Francis McLean, 38 Elm.  
 1923 Ferguson, Roy Cameron, 57 Union.  
 1918 Flaherty, John Edward, 42 Elm.  
 1921 Metcalf, Elliott Harrison, 50 Elm.  
 1897 O'Loughlin, Thomas Francis, 26 N. Park.  
 1931 Schneider, William, 34 Union.

WILLINGTON

WEST WILLINGTON

- 1928 Converse, Frank Benjamin.

OUT OF COUNTY

- 1931 Aiken, Sidney, Cor. Main and E. Centre sts.,  
 Manchester.  
 1937 Gilmour, Omar Wood, Wassaic, N. Y.

Total number 23

WINDHAM COUNTY

*President*, CECIL R. GARCIN, 7 Broad Street, Danielson.  
*Vice-President*, HORTON ARNOLD, M.D., 781 Main Street,  
 Willimantic.

*Secretary*, RALPH L. GILMAN, M.D., Storrs, Conn.

*Councilor*, ROBERT C. PAINE, M.D., Thompson.

*Censors*

(One elected annually for a term of three years)

BRAE RAFFERTY, M.D., 807 Main Street, Willimantic.  
 KARL T. PHILLIPS, M.D., 66 Main Street, Putnam.  
 ERNEST R. PIKE, East Woodstock.

*Committee on Public Policy and Legislation*

(Elected annually)

JOSEPH A. GIROUARD, M.D., 19 Union Street, Willimantic.  
 WILLIAM MAC SHEPARD, M.D., 66 Main Street, Putnam.  
 KARL T. PHILLIPS, M.D., 66 Main Street, Putnam.

*Committee on Medical Ethics and Deportment*

(Two appointed annually by the President  
 for a term of three years)

FRANK P. TODD, 198 Main Street, Danielson.  
 ERNEST R. PIKE, East Woodstock.  
 EDWARD J. OTTENHEIMER, M.D., 29 North Street, Willimantic.  
 ROBERT C. PAINE, M.D., Thompson.  
 KARL T. PHILLIPS, M.D., 66 Main Street, Putnam.  
 MICHAEL D. RIORDAN, M.D., 29 North Street, Willimantic.

RALPH L. GILMAN, Storrs, *Recorder*.

*Committee on Medical Economics*

GERARD M. CHARTIER, M.D., 136 Main Street, Danielson.  
 JOSEPH A. LAPALME, M.D., 158 Main Street, Putnam.

KARL T. PHILLIPS, 66 Main Street, Putnam.

Annual Meeting, Third Thursday in April.

Semi-Annual Meeting, Third Thursday in October.

CANTERBURY

- 1936 Baldwin, Helen.

HAMPTON

- 1914 Marsh, Arthur Drought.

KILLINGLY

DANIELSON

- 1935 Chartier, Gerard Marcel, 136 Main.  
 1928 Garcin, Cecil Redvers, 7 Broad.  
 1938 Lambert, George S., 41 Broad.  
 1909 Perreault, Joseph Napoleon, 43 Main.  
 1919 Tanner, Warren Avery, 36 Academy.  
 1920 Todd, Frank Paige, 178 Main.

PLAINFIELD

- 1903 Chase, Arthur Alverdo, Railroad ave.  
 1933 Gulino, Angelo James.

PUTNAM

- 1934 Chapnick, Morton Herman, 168 Main.  
 1930 Dean, Florence Franklin, 32 S. Main.  
 1927 LaPalme, Joseph Antonio, 158 Main.  
 1919 Murphy, Bernard Patrick, 205 Main.  
 1921 Phillips, Karl Tristram, 66 Main.  
 1922 Russell, John Jarvis, Bridge and Main.  
 1934 Shepard, William Mac, 66 Main.

THOMPSON

- 1903 Paine, Robert Child.

NORTH GROSVERNORDALE

- 1936 Roy, Joseph Lambert.

WINDHAM

WILLIMANTIC

- 1935 Arnold, Morton, 781 Main.  
 1939 Basden, Edward Herbert, 199 Church.  
 1939 Carter, George Howard, 288 North.  
 1901 Girouard, Joseph Arthur, 19 Union.  
 1896 Hills, Laura Heath, 727 Main.  
 1913 Jenkins, Charles Albert, 715 Main.  
 1928 Kinney, Kenneth Kyle, 29 North.  
 1925 Ottenheimer, Edward Joseph, 29 North.  
 1932 Rafferty, Francis Brae, 807 Main.  
 1916 Riordan, Michael Davitt, 29 North.  
 1936 Roch, George Emile, 33 Church.  
 1937 Rothblatt, Reuben, 33 Church.  
 1914 Shea, Richard Edward, 850 Main.  
 1914 Smith, Fred Morse, 736 Main.  
 1935 Vernon, Sidney, 828 Main.

WOODSTOCK

EAST WOODSTOCK

- 1913 Pike, Ernest Reginald.

OUT OF COUNTY

- 1910 Downing, Francis, 287 Main st., Norwich.  
 1883 Foster, Warren Woden, 4000 Cathedral ave.,  
 Washington, D. C.  
 1932 Gilman, Ralph Lawrence, Storrs.  
 1929 Spector, Nathan, 60 Broad St., Lynn, Mass.

Total number 39

SUMMARY

FAIRFIELD COUNTY . . . . .	379
HARTFORD COUNTY . . . . .	532
LITCHFIELD COUNTY . . . . .	78
MIDDLESEX COUNTY . . . . .	70
NEW HAVEN COUNTY . . . . .	517
NEW LONDON COUNTY . . . . .	119
TOLLAND COUNTY . . . . .	23
WINDHAM COUNTY . . . . .	39

TOTAL . . . . . 1757

# Alphabetical Roll of Members

With date and place of graduation.

- Aaronson, M. S., Univ. & Bellevue, '13, Ansonia.  
 Abbey, E. A., B.A., Mt. St. Mary's, '26, Georgetown, '30, New Haven.  
 Abrahams, M., Tufts, '31, New Canaan.  
 Abrashkin, M. D., Maryland, '32, New Haven.  
 Adam, F. S., Ph.B., Boston U., '21, Yale, '25, Canaan.  
 Adzima, J. M., Univ. Md., '27, Bridgeport.  
 Affinito, T., B.S., Yale, '26, McGill, '31, Meriden.  
 Agnew, R. R., Yale, '08, Norwich.  
 Aiken, S., Toronto U., '29, Manchester (Tolland Co.)  
 Alderman, I. S., Ph.B., Yale, P. & S., N. Y., '19, New Haven.  
 Allen, E. P., B.A., Lebanon Valley (Pa.) Coll., '20, Yale, '24, New Haven.  
 Allen, H. E., B.A., Bowdoin, '15, Bowdoin, '19, Waterbury.  
 Allen, H. S., Yale, '04, Woodbury.  
 Allen, M. F., Med. Chi., Phila., '95, New Haven.  
 Allen, W. M., B.A., Haverford, '16, Johns Hopkins, '20, Hartford.  
 Alling, A. N., B.A., Yale, '86, P. & S., N. Y., '91, New Haven.  
 Allyn, L. M., Univ. Pa., '03, Mystic.  
 Alpert, M., B.S., Yale, Yale, '28, Bridgeport.  
 Alpert, R. H., Yale '13, New Haven.  
 Alu, A. F., Yale, '20, Ansonia.  
 Amatruda, F. G., B.A., Yale, '20, Yale, '23, New Haven.  
 Amos, I. L., McGill, '26, Danbury.  
 Amoss, H. L., BS., Univ. Ky., '05; M. S., Univ. Ky., '07; D.P.H., Harvard, '12; Sc.D. (Hon.) Geo. Wash., '22, Harvard, '11, Greenwich.  
 Anderson, C. W., A.B., Colgate, '30, Harvard, '34, New Haven.  
 Andrus, O. B., B.A., Dartmouth, '28, Univ. & Bellevue, '32, Devon.  
 Andrews, E. M., Univ. Maine, '25; Harvard, '30, Hartford.  
 Angus, L. R., B.A., Toronto, '25, Toronto U., '28, Hartford.  
 Ansell, H. B., Tufts, '32, Jewett City.  
 Antell, M. J., B.S., Middlebury, '25, Univ. Vt., '29, Bridgeport.  
 Antupit, L., B.S., Trinity, '19, Jefferson, '23, Hartford.  
 Appell, H. S., Tufts, '27, West Haven.  
 Appeli, P. H., Univ. & Bellevue, '23, Bristol.  
 Apsel, A., Ph.G., Brooklyn Coll. Phar., '13, L. I. Coll. Hosp., '18, Bridgeport.  
 Apter, H., B.A., Geo. Wash., '31, Geo. Wash., '34, Hartford.  
 Archambault, H. A., Tufts, '27, Taftville.  
 Armstrong, G. G., U. City N. Y., '91, Middletown.  
 Arnold, H. B., B.A., Yale, '23, Yale, '26, New Haven.  
 Arnold, H. S., B.A., Yale, '00, Yale, '03, New Haven.  
 Arnold, M., B.A., Harvard, '25, Harvard, '29, Willimantic.  
 Arons, M. R., Ph.B., Yale, '25, Univ. Md., '30, Hartford.  
 Ashcroft, A. D., P. & S. Coll., '35, Stratford.  
 Ashley, H. C., Univ. Va., '26, New Hartford.  
 Atha, H. G., Ph.B., Brown U., '27, Tufts, '34, Thomaston.  
 Atkins, S. M., Tufts, '22, Waterbury.  
 Atkinson, E., Univ. Vt., '93, Niantic.  
 Audet, C. H., Univ. Md., '17, Waterbury.  
 Austin, A. E., B.A., Amherst, M.A., Amherst, '04, Jefferson, '05, Old Greenwich.  
 Awdziejewicz, F. J., B.S., Yale, '29, Yale, '32, Stamford.  
 Backer, M., Yale, '24, Bridgeport.  
 Backus, H. S., L. I. Coll. Hosp., '03, Hartford.  
 Bailey, H., B.A., Yale, '19, Univ. Md., '22, Hartford.  
 Bailey, N. H., P. & S., Balt., '11, Hartford.  
 Baker, P. G., B.S., Univ. Vermont, '30, Univ. Vermont, '33, Winsted.  
 Bakunim, M. I., B.S., Yale, '28, Jeff., '32, Bridgeport.  
 Baldwin, C. T., Bellevue, '83, Derby.  
 Baldwin, H., B.A., Wellesley, '88, Wom. Med., N. Y., '92, Canterbury.  
 Bladwin, W. P., B.A., Yale, '88, Yale, '90, N.Y. Homeo., '91, New Haven.  
 Bancroft, H. A., Albany Med., '16, Hartford.  
 Banks, D. T., Fordham, '12, Bridgeport.  
 Bannon, F. M., Univ. Vt., '28, Stamford.  
 Barber, W. L., Jr., B.A., Yale, '03, Univ. & Bellevue, '07, Waterbury.  
 Bard, G. P., N. Y. Homeo., '00, Stafford Springs.  
 Barker, A. J., Bellevue, '97, Torrington.  
 Barker, C., Dartmouth, '13, New Haven.  
 Barnes, F. H., N. Y. Homeo., '96, Stamford.  
 Barnes, W. S., Ph.B., Yale, '95, Yale, '97, New Haven.  
 Barney, W. E., B.S., Catholic U., '31, Yale '35, Milford.  
 Barnum, C. G., B.A., Middlebury Coll., '05; M.A., Middlebury Coll., '07, Yale, '11, Groton.  
 Baron, S. H., Cornell, '27, New London.  
 Barrett, W. J., Md. Med., '04, New Haven.  
 Barry, J. C., Boston U., '33, Jewett City.  
 Barstow, R. I., B.A., Union Coll., '29, Jeff., '33, Norfolk.  
 Bartlett, C. J., B.A., Yale, '92; M.A. Yale, '94, '95, New Haven.  
 Basden, E. H., Tufts, '33, Willimantic.  
 Bassin, A. L., Rochester, '30, New Haven.  
 Batelli, C. F., BA., Yale, '25, Yale, '28, New Haven.  
 Battista, A. W., Tufts, '24, New Haven.  
 Bausch, C. P., Tufts, '29, Hartford.  
 Bayne-Jones, S., B.A., Yale, '10; M.A., Johns Hopkins, '17, Johns Hopkins, '14, New Haven.  
 Beach, C. C., Ph.B., Yale, '77, P. & S., N. Y., '82, Hartford.  
 Beach, C. T., Yale, '05, Hartford.  
 Beatman, I., B.S., Trinity, '23, Tufts, '27, Hartford.  
 Beatrice, A. A., Tufts, '29, Bristol.  
 Beauchemin, J. A., Montreal U., '25, Middletown.  
 Beaudry, J. H., McGill, '13, Bridgeport.  
 Beck, E. C., Yale, '26, So. Norwalk.  
 Beck, F. G., Yale, '03, New Haven.  
 Becker, J., B.S., N. Y. U., '26, Univ. & Bellevue, '29, New London.  
 Beckwith, D. M., A.B., Johns Hopkins, '28, Harvard, '34, Rockville.  
 Behan, E. J., McGill, '22, New Haven.  
 Beizer, E., B.A., Harvard, '25, L. I. Coll. Hosp., '30, Hartford.  
 Bell, J. S., Ph.G., Valparaiso, '14, Loyola, '18, Brooklyn, N. Y. (New Haven Co.)  
 Bell, J. S., Illinois, '28, Ridgefield, Torrington.  
 Benedict, M. K., Johns Hopkins, '19, New Haven.  
 Benoit, R. J., Georgetown, '26, New Britain.  
 Bergendahl, H. A., Tufts, '33, Taftville.  
 Bergin, E. P., B.A., Georgetown, '27, Georgetown, '31, 440 E. 141st St., N. Y. C.  
 Bergin, T. J., Yale, '99, Cos Cob.  
 Bergman, A., B.S., Stockholm, '89, U. City N. Y., '95, New Haven.  
 Berman, B. A., Tufts, '34, Waterbury.  
 Berman, H. L., B.A., Yale, '13, Yale, '15, New Haven.  
 Bernstein, A., Yale, '08, Bridgeport.  
 Bernstein, D. J., B.S., Univ. Vt., '30, Univ. Vt., '33, New Britain.  
 Bestor, E. L., N. Y. Homeo., '07, Hartford.  
 Bevans, T. F., Univ. Minn., '03, Waterbury.  
 Bidgood, C. Y., B.S., Univ. Va., '19, Univ. Va., '20, Hartford.  
 Biehn, S. L., B.S., Toronto U., '26, Fairfield.  
 Bienkowski, J. G., B.S., Trinity, '30, Howard, '35, Torrington.  
 Bill, P. W., Ph.B., Yale, '97; P. & S. N. Y., '01, Westport.  
 Bingham, C. T., B. A., Yale, '28, P. & S., N. Y., '32, Hartford.  
 Biram, J. H., Cornell, '10, Hartford.  
 Bird, F. S., B.S., Univ. Vt., '30, Univ. Vt., '33, Bristol.  
 Birdsong, J. L., B.S., Nashville U., '99, Johns Hopkins, '09, Hartford.  
 Birge, H. L., Dartmouth, '30, Penn., '33, Hartford.  
 Bishop, C. C., Yale, '30, New Haven.  
 Bissell, A. H., Litt.B., Princeton, '12, Cornell, '16, Stamford.  
 Bizzozero, O. J., B.S., Univ. Vt., '24, Univ. Vt., '27, Waterbury.  
 Blair, E. H., P. & S., Balt., '06, Hartford.  
 Blake, E. M., Yale, '06, New Haven.  
 Blake, F. G., B.A., Dartmouth, '08, Harvard, '13, New Haven.  
 Blanchard, D. L., B.S., Bowdoin, '27, Yale, '25, Branford.  
 Blank, E. F., Starling, '97, Bridgeport.



- Blank, E. H., Univ. Vt., '25, New London.  
 Blodinger, I. E., Ph.B., Yale, '22, Yale, '25, New Haven.  
 Blogoslawski, W. J., Georgetown, '27, New Britain.  
 Bloom, D. I., Conn. State, '30, Tufts, '35, Thompsonville.  
 Blum, M., Tulane, '25, New Haven.  
 Blumenthal, E. J., B.S., Yale, '28, L. I. Coll., '32, Ansonia.  
 Blumer, G., M.A., Yale, '07, Cooper, '91, New Haven.  
 Boardman, A. K., Univ. Pa., '99, New Haven.  
 Boardman, E. I., B.A., Smith, '15, Cornell, '20, Waterbury.  
 Bodie, J. A., Tufts, '24, New Haven.  
 Bodie, W. J., Georgetown, '29, Branford.  
 Bodley, G. H., Yale, '07, New Britain.  
 Bogin, M., B.S., Yale, '23, Yale, '26, Bridgeport.  
 Boisvert, P. L., B.S., Hobart, '30, Rochester, '34, New Haven.  
 Bonoff, Z. A., Yale, '04, New Haven.  
 Booe, J. G., B.A., '16, B.S., '17, Wake Forest Coll. N. C., Med. Coll. Va., '19, Bridgeport.  
 Booth, J. D., B.S., Dartmouth, P. & S., N. Y., '26, Danbury.  
 Borkowski, B. J., Georgetown, '28, Bristol.  
 Botsford, C. P., Yale, '94, Hartford.  
 Bowman, S. H., Hahn, Chicago, '13, Stamford.  
 Boyarsky, H. M., B.S., Tufts, '28, Tufts, '31, Wallingford.  
 Boyd, H., B.S., Allegheny Coll., '15, Harvard, '21, South Manchester.  
 Brackett, A. S., B.A., Yale, '92, Jefferson, '95, Bristol.  
 Bradeen, F. B., Univ. Pa., '99, Essex.  
 Bradley, T. R., Univ. Md., '14, South Norwalk.  
 Brainard, C. B., Ph.B., Yale, '94, Yale, '98, Hartford.  
 Branon, A. W., Jefferson, '13, Hartford.  
 Brayton, H. W., Ph.B., Brown, '06, Harvard, '11, Hartford.  
 Breck, C. A., Ph.B., Yale, '26, Yale, '30, Wallingford.  
 Brecker, F. W., Tufts, '28, East Hartford.  
 Brennan, E. L., Univ. of Ireland, '23, Hartford.  
 Brennan, P. J., Yale, '07, Waterbury.  
 Bretzfelder, K. B., Jefferson, '16, New Haven.  
 Brewer, F., A.B., Oberlin, Columbia, '20, Brookfield Center.  
 Brewer, T. F., Yale, '26, Hartford.  
 Bridge, J. L., B.S., Wesleyan, '88; Ph.D., Clark, '94, Harvard, '03, Hazardville.  
 Bristol, D. A., B.A., Hamilton, '23, Univ. Pa., '27, New Britain.  
 Brodsky, M. E., B.A., Clark, '19, Northwestern, '26, Bridgeport.  
 Brody, B. S., B.A., Yale, '25, Yale, '28, New Haven.  
 Bronson, W. T., N. Y. U., '98, Danbury.  
 Brophy, E. J., Yale, '04, Norwich.  
 Brosnan, J. F., Tufts, '30, New London.  
 Brown, A. S., B.A., Yale, '23, Yale, '26, Waterbury.  
 Brown, C. H., U. City N. Y., '93, Waterbury.  
 Brown, D. C., Yale, '84, Danbury.  
 Brown, P. H., Univ. Vt., '26, Stamford.  
 Bruckner, W. J., B.S., N. Y. Univ., '29, Cornell, '33, New Haven.  
 Bruyere, P. T., B.A., Princeton, '30, Univ. Chicago, '34, Kent.  
 Bryon, B. A., Bellevue, '90, Norwalk.  
 Bucciarelli, J. A., Temple, '31, New Canaan.  
 Buck, B. J., B.A., Colgate, '22, Harvard, '26, Hartford.  
 Buckhout, G. A., Tufts, '35, Bridgeport.  
 Buckley, R. C., B.S., Trinity, '20, Yale, '24, Hartford.  
 Buckley, J. W., Georgetown, '33, Bridgeport.  
 Buckmiller, F. C., Univ. Vt., '14, Bridgeport.  
 Budau, J. H. D., Yale, '00, Milford.  
 Buffum, J. H., Ph.B., Univ. Vt., '96, Univ. Vt., '98, Wallingford.  
 Bull, J. N., P. & S., N. Y., '78, Plainville.  
 Bumstead, J. H., B.A., Yale, '19, Johns Hopkins, '23, New Haven.  
 Bunnell, W. W., B.S., Lafayette, '25, Yale, '29, Farmington.  
 Buol, R. S., B.S., Univ. Mich., '21, Harvard, '23, New Britain.  
 Burdsall, E. S., Hahn, Phila., '11, New London.  
 Burgdorf, A. L., B.S., Chicago, '27, Rush, '31, Bloomfield.  
 Burke, F. H., B.S., Georgetown, '29, Georgetown, '31, Rockville.  
 Burke, W., L. I. Coll. Hosp., '96, Greenwich.  
 Burlingame, C. C., Hahn, Chicago, '08, Hartford.  
 Burns, G. D., Yale, '25, Derby.  
 Burns, M., M.B., B.A., Univ. Texas, '23, Univ. Texas, '27, Hartford.  
 Burr, N. A., Yale, '01, Higganum (Hartford Co.).  
 Butler, N. G., Tufts, '24, Hartford.  
 Byrne, D. W., B.A., Wesleyan, '23, P. & S., N. Y., '27, New York City (Hartford Co.).  
 Caldwell, D. M., McGill, '19, South Manchester.  
 Calhoun, H. A., B.S., Colby, '30, Tufts, '34, Middletown.  
 Callahan, J. W., P. & S., Balt., '11, Norwich.  
 Calverley, E. J., T. Wom. Med., Pa., '08, Hartford.  
 Calvin, C. V., Harvard, '16, Bridgeport.  
 Cammaun, D. DeN., Ph.B., Yale, Columbia, '33, New Canaan.  
 Campbell, H. B., Univ. Pa., '09, Norwich.  
 Campbell, S., Univ. Vt., '23, Meriden.  
 Canfield, N., B.S., Dartmouth, '25, Univ. Mich., '29, New Haven.  
 Cantarow, D., Tufts, '11, Hartford.  
 Cantor, P. J., B.S., N. Y. Univ., '30, Glasgow, '35, Norwich.  
 Cantrell, R. F., Univ. Okla., '28, New London.  
 Capececlatro, A., Tufts, '19, New Haven.  
 Caplan, H., Yale, '27, Meriden.  
 Caplan, M., B.S., Yale, '26, Louisville, '33, Meriden.  
 Cappiello, S., Tufts, '19, Hartford.  
 Carelli, G. F., Yale, '11, New Haven.  
 Carey, T. C., B.S., Trinity, '24, Yale, '28, Hartford.  
 Carey, W. C., Columbia, '33, Meriden.  
 Carlin, C. H., Univ. Mich., '96, Torrington.  
 Carnigila, E. F., B.A., Harvard, '25, Harvard, '29, Hartford.  
 Carpenter, R. M., Loyola, '16, Stamford.  
 Carr, V. T., Hahn, Chicago, '07, Norwich.  
 Carroll, F. P., B.S., Trinity, '10, Johns Hopkins, '14, Bridgeport.  
 Carroll, J. E., B.S., Colgate, '21, Boston U., '25, Hartford.  
 Carroll, P. R., Jr., Georgetown, '29, Bridgeport.  
 Carroll, W. E., B.A., Dartmouth, '11, Dartmouth, '14, Meriden.  
 Carrozzella, J. C., B.S., Yale, '24, L. I. Coll. Hosp., '28, Wallingford.  
 Carson, R. J., Toronto Univ., '23, Norwich.  
 Carter, E. B., Ph.B., Yale, '07, Johns Hopkins, '11, Hartford.  
 Carter, G., B.S., B.A., M.A., Johns Hopkins, '28, Greenwich.  
 Carter, G. H., A.B., Amherst, '31, P. & S., '35, Willimantic.  
 Carvey, E. V., Yale, '29, Yale, '35, Wethersfield.  
 Carwin, J. L., B.A., Morehouse, '26, Meharry, '32, Stamford.  
 Casagrande, J. J., B.S., Fordham, '27, St. Louis, '32, Ansonia.  
 Case, E. P., Ph.D., Lafayette, '05, Univ. Mich. Homeo., '11, West Hartford.  
 Case-Downer, M., Boston U., '29, Hamden.  
 Caulfield, E. J., Johns Hopkins, '20, Hartford.  
 Celentano, L. E. H., B.S., Trinity, '24, Hahn, Phila., '30, New Haven.  
 Cenci, V. P., Tufts, '29, Hartford.  
 Chaffee, J. S., Ph.B., Yale, '94, Univ. Pa., '97, Ft. Lauderdale, Fla. (Litchfield Co.).  
 Chalmers, H. E., Tufts, '06, New Britain.  
 Chapnick, M. H., B.S., M.S., Trinity, Jefferson, '32, Putnam.  
 Chartier, G. M., B.A., Assumption, '29, Boston U., '33, Danielson.  
 Chase, A. A., Harvard, '01, Plainfield.  
 Chase, C. C., Univ. Vt., '24, Middletown.  
 Chasoff, J. A., B.S., Yale, '31, L. I. Med. Coll., '36, New Haven.  
 Cheney, B. A., B.A., Yale, '88, Yale, '90, New Haven.  
 Cheney, G. P., Md. Med., '13, New London.  
 Cheney, M. L., Univ. Vt., '17, Bridgeport.  
 Chernaik, S. J., Jefferson, '16, New Britain.  
 Childs, A. E., N. Y. U., '96, Litchfield.  
 Chipman, S. S., B.A., Acadia, '24, McGill, '28, Norwalk.  
 Chobian, J. A., A.B., Holy Cross, '29, Loyola, '33, Seymour.  
 Ciminera, J. A., Vermont, '16, Waterbury.  
 Claiborn, L. N., Washington, '27, New Haven.  
 Clark, J. B., P. & S., N. Y., '98, Greenwich.  
 Clark, M. H., Wom. Med., Pa., '33, New Haven.  
 Clarke, C. C., B.A., Yale, '27, Yale, '32, D.M.S., Columbia, '38, New Haven.  
 Clarke, J. A., Bellevue, '97, Greenwich.  
 Clarke, R. deB., B.A., N. Y. U., '04, Johns Hopkins, '08, Hartford.  
 Clarke, W. C., P. & S., N. Y., '99, Cornwall Bridge.  
 Clason, F. P., B.A., Bates, '11, Harvard, '15, Hartford.  
 Cleary, H. J., Tufts, '29, Watertown.  
 Clifford, M. L., B.A., Univ. Colorado, '30, C.P.H., Johns Hopkins, Univ. Colorado, '33, W. Hartford.  
 Clifton, H. C., Univ. Pa., '01, Hartford.  
 Climan, M., B.A., Yale, P. & S., N. Y., '15, Hartford.  
 Climo, S., Ohio State, '29, New Haven.  
 Cloonan, J. J., P. & S., Balt., '97, Stamford.  
 Close, J. F., B.A., Colgate, '21, P. & S., N. Y., '25, Greenwich.  
 Clow, H. L., Tufts, '14, Mansfield Depot.  
 Cogteo, S. P., Lehigh, '30, Maryland, '34, Suffield.  
 Cobb, A. E., Yale, '98, Canaan (Hartford Co.).  
 Cobey, J. F., Ph.B., Yale, '12, Yale, '16, New Haven.  
 Cochran, L. B., Univ. Pa., '93, Hartford.  
 Coffey, J. R., B.A., Yale, '03, Yale, '07, New Haven.

- Cofrances, L. W., Jefferson, '23, New Haven.  
 Cogan, G. E., B.S., Georgetown, '21, Georgetown, '23, Hartford.  
 Cogswell, E. S., Harvard, '12, Hartford.  
 Cogswell, L. P., A.B., Univ. Maine, '27, Harvard, '33, Hartford.  
 Cohane, J. J., Yale, '98, New Haven.  
 Cohane, T. F., Yale, '97, New Haven.  
 Cohen, D. J., Yale, '32, Meriden.  
 Cohen, J., B.A., Coll. City N. Y., '94, Eclectic, N. Y., '09, Bridgeport.  
 Cohen, W., Ph.B., Yale, '20, Yale, '23, New Haven.  
 Cohn, S. H., Boston, '30, '34, Hartford.  
 Coleburn, A. B., Ph.G., N. Y. Coll. Pharm., '84, P. & S., N. Y., '90, Norwalk (Middlesex Co.).  
 Collins, J. O., Baylor, '29, Waterbury.  
 Collins, W. F., Yale, '04, New Haven.  
 Colomb, A. C., B.A., Univ. of Calif., '22, Univ. of Calif., '26, Middletown.  
 Colomb, H. O., Tulane, '23, Middletown.  
 Colwell, H. S., B.S., Colgate, '10, Johns Hopkins, '14, New Haven.  
 Comfort, C. W., Jr., B.A., Yale, '07, Yale, '11, New Haven.  
 Compson, F. E. M., B.A., Geo. Wash., '19, Boston U., '20, Middletown.  
 Comstock, E. R., B.S., Tufts, '30, Tufts, '33, New London.  
 Conklin, C. S., Fordham, '16, Bridgeport.  
 Connolly, A. J., B.S., Georgetown, '24, Georgetown, '28, New Haven.  
 Connor, J. J., B.S., Trinity, '26, Yale, '30, Hartford.  
 Connor, G. M., Villanova, '31, Boston Univ., '35, Plantsville.  
 Connors, E. R., Boston U., '31, Bridgeport.  
 Conroy, M. J., B.A., Yale, '18, Yale, '20, Meriden.  
 Conte, H. A., L. I. Coll. Hosp., '12, New Haven.  
 Converse, F. B., Eclectic, Cinn., '94, West Willington.  
 Cook, G. F., Tufts, '23, Plainville.  
 Cook, R. J., B.A., Iowa, '09, Johns Hopkins, '13, New Haven.  
 Cooley, C. M., Yale, '08, New Britain.  
 Corbett, H. J., Tufts, '29, Waterbury.  
 Corcoran, M. A., Tufts, '30, Hartford.  
 Corey, W. VanA., Geo. Wash., '33, Hamden.  
 Cornelio, F. J., B.S., Niagara, '30, Georgetown, '34, Winsted.  
 Cornwell, P. M., B.S., Trinity, Yale, '34, E. Hartford.  
 Corradino, C. L., Tufts, '29, New Haven.  
 Corridon, J. D., B.A., Fordham, '24, Georgetown, '28, So. Norwalk.  
 Costanzo, J. J., Univ. Ill., '05, Stamford.  
 Costello, H. N., B.A., Yale, '06, Johns Hopkins, '10, Hartford.  
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 Curran, E. R., Jefferson, '24, Union City.  
 Curran, H. J., Tufts, '24, Thomaston.  
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- Evarts, J., B.A., Vassar, '24, P. & S., N. Y., '29, Cornwall Bridge.
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- Farland, V. L., B.A., Joliet, '20, Montreal U., '25, Hartford.
- Farrell, J. E., Univ. & Bellevue, '03, Waterbury.
- Fauver, E., P. & S., N. Y., '09, Middletown.
- Fawcett, G. G., Cornell, '15, South Norwalk.
- Fay, W. J., B.A., '10, Harvard, '14, Hartford.
- Fekety, S. H., Tufts, '30, Middletown.
- Felt, P. R., B.A., Dartmouth, Dartmouth, '10, Middletown.
- Felty, A. R., B.A., Yale, '16, Johns Hopkins, '20, Hartford.
- Fenimore, B. B., Hahn, Phila., '04, Mansfield Depot.
- Fenney, P. W., B.S., N. Y. U., '27, Tufts, '31, New Haven.
- Ferguson, H. K., B.S., Conn. Coll., '25, N. Y. U. & Bellevue, '32, New London.
- Ferguson, J. A., M.S., W. Ont., '30, W. Ontario, '25, Burlington, Vt. (New Haven Co.).
- Ferguson, R. C., B.A., Yale, '18, Yale, '20, Rockville.
- Ferguson, R. J., Hahn, Phila., '89, New Haven.
- Ferris, H. B., B.A., Yale, '87, Yale, '90, New Haven.
- Filson, R. M., B.A., Queen's, '13, Queen's, '15, Garden City, L. I., N. Y. Hartford Co.).
- Fincke, C. L., B.A., Harvard, '24, Harvard, '28, Stamford.
- Findorak, F. G., B.S., Georgetown, '32, Stratford.
- Fine, B., B.S., Univ. Pa., '28, Jefferson, '32, Stamford.
- Fine, J., Univ. Pa., '31, Stamford.
- Finkelstein, W., Harvard, '34, Waterbury.
- Finklestone, B. B., P. & S., Balt., '10, Bridgeport.
- Finley, G. C., Tufts, '24, Hartford.
- Finn, A. J., B.A., Bowdoin, '17, Bowdoin, '21, Waterbury.
- Finn, E. J., Yale, '10, Shelton.
- Fischer, W. J. H., Yale, '11, Milford.
- Fisher, J. W., Wom. Med., Pa., '93, Middletown.
- Fiske, M., B.A., Vassar, Boston U., '27, Stamford.
- Fiskio, P. W., B.S., Yale, '24, Yale, '27, New Haven.
- Fitzgerald, C. J., Univ. Vt., '98, New Haven.
- Fitzpatrick, E. E., Ph.G., R. I. Coll. Phar., '07, Univ. Md., '15, Waterbury.
- FitzSimons, E. F., Tufts, '24, New Haven.
- Flaherty, C. V., Yale, '10, Hartford.
- Flaherty, H. F., Yale, '07, Hartford.
- Flaherty, J. E., Georgetown, '08, Rockville.
- Flanagan, W. F., Fordham, '17, New Britain.
- Fleck, H. W., Jefferson, '96, Bridgeport.
- Flynn, C. T., Yale, '11, New Haven.
- Flynn, D. A., Yale, '05, New Haven.
- Fynn, H. A., B.A., Yale, '23, Yale, '27, New Haven.
- Flynn, W. H., Univ. Md., '16, Bristol.
- Foley, F. X., A.B., Boston U., '34, Bridgeport.
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- Foster, H. J., B.S., Colby, '03, Univ. Pa., '17, Waterbury.
- Foster, L. C., B.A., Univ. Kansas, '19, Harvard, '23, New Haven.
- Foster, W. W., Harvard, '82, Washington, D. C. (Windham Co.).
- Fox, J. C., Jr., B.A., Williams, '16, Johns Hopkins, '20, New Haven.
- Frank, H. S., B.A., Wesleyan, '21, P. & S., N. Y., '24, Middletown.
- Freedman, B. P., Ph.B., Yale, '17, Yale, '20, New Haven.
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- Freeman, J. J., Columbia, '24, Temple, '33, Newington.
- Friedman, N. H., B.S., Tufts, Tufts, '33, Stratford.
- Freiheit, J. M., B.S., Yale, '24, Yale, '27, Waterbury.
- Fridberg, S., B.S., Coll. City N. Y., '19, L. I. Coll. Hosp., '28, Stamford.
- Friedman, I., Geo. Wash., '31, Colchester.
- Friend, A. E., Queen's, '22, South Manchester.
- Friery, C. M., B.A., Harvard, '25, Boston U., '29, Hartford.
- Frost, L. H., Univ. Vt., '13, Plainville.
- Frothingham, J. G., A.B., Harvard, Harvard, '35, New Canaan.
- Fruin, J. W., L. I. Coll. Hosp., '08, Waterbury.
- Fry, C. C., Northwestern, '24, New Haven.
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- Furniss, H. W., Howard, '91, Hartford.
- Gaberman, D., P. & S., N. Y., '20, Hartford.
- Gade, C. J., Yale, '10, Bridgeport.
- Gaetz, T. H., McGill, '24, Shelton.
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- Garland, R. B., P. & S., Balt., '13, Hartford.
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- Garston, L. E., St. Louis U., '30, Torrington.
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 Haliday, E. G., Queen's, '27, Stonington.  
 Hall, L., B.A., Harvard, '20, Harvard, '24, Hartford.  
 Hall, M. I., Edinburg, '34, Bristol.  
 Hall, W. C., U. of Penna., '30, B.A., U. of Texas, '26, Hartford.  
 Hall, W. E., B.A., Yale, '22, Yale, '25, Meriden.  
 Hamilton, J. S. M., McGill, '26, Stamford.  
 Hanchett, H. B., Jefferson, '05, Torrington.  
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 Harrington, J. L., Jefferson, '03, Mystic.  
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 Harris, J. S., Yale, '32, New Haven.  
 Harris, L. D., Tufts, '34, Hartford.  
 Harrison, E. R., Yale, '26, New Haven.  
 Harrison, F. M., A.B., Holy Cross, '17, Jefferson, '22, Stamford.  
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 Hart, C. J., Hahne, Phila., '03, New Britain.  
 Hartman, F. B., A.B., Hamilton, '30, Harvard, '34, New Haven.  
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 Harvey, D. F., Yale, '33, Hartford.  
 Harvey, J. LeR., Louisville U., '14, Waterbury.  
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 Heady, C. K., Jefferson, '13, Milford.  
 Heidger, L. C., Univ. Vt., '21, Stratford.  
 Hendel, I., Jefferson, '17, New London.  
 Henderson, A. C., B.S., Amherst, '99, P. & S., N. Y., '03, Stamford.  
 Henderson, J., B.S., Smith, '26, P. & S., N. Y., '31, Stamford.  
 Hendricks, A. L., Yale, '07, New Haven.  
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 Henkle, R. T., B.A., Cornell, '27, Cornell, '31, New London.  
 Hennessey, E. H. J., Univ. Md., '12, Stratford.  
 Hennessey, J. G., Tufts, '34, Bridgeport.  
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 Hetzel, J. L., Yale, '26, Waterbury.  
 L'Heureux, J. A., B.A., Assumption, '30, Boston, '34, Meriden.



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 Heyer, H. H., U. City N. Y., '87, New London.  
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 Higgins, E. C., Tufts, '25, South Manchester.  
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 Hitchcock, F. St. C., N. Y. Homeo, '07, Greenwich.  
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 Hoffman, W. E., Hahn, Chicago, '05, New Hartford.  
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 Jackson, A. J., P. & S., N. Y., '15, Waterbury.  
 Jackson, E. B., Johns Hopkins, '21, New Haven.  
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 James, G. R., Yale, '10, New Haven.  
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 Johnson, A. A., P. & S., N. Y., '90, Waterbury.  
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 Johnson, E. M., Yale, '14, New Haven.  
 Johnson, H. A., Univ. Vt., '25, Naugatuck.  
 Johnston, E. H., Univ. Md., '00, Waterbury.  
 Jones, F. S., Yale, '28, Hartford.  
 Jordan, R. H., Virginia, '30, New Haven.  
 Joslin, G. H., Univ. Vt., '87, Mt. Carmel.  
 Joyce, W. M., Jefferson, '17, Middletown.  
 Kahn, E., Munich, '11, New Haven.  
 Kalett, J., Jefferson, '28, New Britain.  
 Kalin, J. I., B.A., Clark, '20, Harvard, '24, Hartford.  
 Kalman, E., Komensky, Czechoslovakia, '23, Bridgeport.  
 Kaminsky, D., Boston U., '34, Noroton Heights.  
 Kane, J. H., Md. Med., '04, Thomaston.  
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 Kardys, J. A., Geo. Wash., '30, Hartford.  
 Karotkin, R. H., B.S., N. Y. U., '29, Univ. & Bellevue, '32, Hartford.  
 Kaschmann, J., Munich U., '22, Hartford.  
 Kaschub, R. W., Tufts, '35, Meriden.  
 Katz, D., Univ. Vt., '22, Univ. Vt., '25, Hartford.  
 Katz, H., B.A., Yale, '17, Harvard, '21, Hartford.  
 Kaufman, C., Jefferson, '19, New London.  
 Keating, J. J., B.S., Niagara, Bellevue, '34, New Milford.  
 Keddy, R. A., McGill, '24, Stamford.  
 Keefe, G. G., B.A., Holy Cross, '18, Univ. Md., '22, Hartford.  
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 Keith, A. R., B.A., Colby, '97, Harvard, '03, Hartford.  
 Kellogg, H. K. W., B.S., Amherst, '89, P. & S., N. Y., '03, Norwalk.  
 Kelly, C. C., B.S., Davidson, '09, Johns Hopkins, '14, Hartford.  
 Kelly, J. F. C., Queen's, '28, Old Greenwich.  
 Kelly, J. F., Hartford.  
 Kemp, E. P., Tufts, '25, Bridgeport.  
 Kendall, R. E., Johns Hopkins, '21, Hartford.  
 Kennard, M. A., Cornell, '30, New Haven.  
 Kennedy, R. C., A.B., B.S., U. of Kansas, '27, Fairfield.  
 Kennedy, W. C., Georgetown, '10, Torrington.  
 Kettle, R. H., Queen's Univ., '28, Norwich.  
 Kezel, A. P. C., B.S., Georgetown, '35, Stamford.  
 Keys, R. C., A.B., B.S., U. of Kansas, '27, Fairfield.  
 Kilbourn, A., B.A., Yale, '21, B.S., Yale, '22, Yale, '23, Hartford.  
 Kilbourn, C. L., Yale, '97, New Haven.  
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 Kingman, J. H., B.A., Yale, '82, P. & S., N. Y., '85, New Haven (Middlesex County).  
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 Kinney, K. K., B.S., Iowa Univ. Iowa, '21, Willimantic.  
 Kinsella, G. C. J., Tufts, '11, New Britain.  
 Kinsella, M. A., Tufts, '12, New Britain.  
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 Klatskin, G., A.B., Cornell, '29, Cornell, '33, New Haven.  
 Klebanoff, H. E., B.A., Yale, Yale, '25, New Haven.  
 Kleiman, A. O., Tufts, '28, Tufts, '33, Hartford.  
 Klein, A. A., Louisville U., '29, Hartford.  
 Kleiner, S. B., Ph.B., Yale, '11, Yale, '15, New Haven.  
 Klinghoffer, K. A., B.A., N. Y. U., '27, M.A., Columbia, '28, Yale, '34, New Haven.  
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 Knapp, C. W., P. & S., N. Y., '12, Greenwich.  
 Knapp, R. P., P. & S., N. Y., '11, South Manchester.  
 Knauth, M. S., Columbia, '23, Wilton.  
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 Kushlan, S. D., Yale, '35, New Haven.  
 LaBella, L. O., B.A., Wesleyan, P. & S., N. Y., '25, Middletown.  
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 Leddy, P. A., Harvard, '24, New Haven.  
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 Levy, A., B.A., Harvard, '25, Tufts, '31, Winsted.  
 Levy, D. F., Ph.B., Yale, '15, Yale, '19, New Haven.  
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 Levy, N., B.S., Yale, '23, Yale, '27, Branford.  
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 Lewis, H. R., B.S., Univ. Idaho, '29, Univ. Oregon, '32, Hartford.  
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 Lindsay, J. C., B.A., Colby, '16, Harvard, '10, Cheshire.  
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 Lirot, S. L. R., McGill, '32, Meriden.  
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 Loiacono, A. J., Ph.B., Brown, '23, Harvard, '27, New London.  
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 Marsh, A. D., Yale, '08, Hampton.  
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 Marshall, C. L., B.A., Williams, '20, Howard, '24, New Haven.  
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 Martin, J. S., Yale, '05, Waterbury.  
 Martin, O. L., U. of Kansas, '37, Bristol.  
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 Mastroianni, L., Univ. Padua, '17, New Haven.  
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 Matteis, J. T., Yale, '26, New Britain.  
 Maurer, L. L., B.A., Beloit, '10, Yale, '16, New Haven.  
 Maxwell, J. A., B.A., St. Bonaventure, '10, Med. Coll. Va., '17, Bridgeport.  
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 McCook, J. B., B.S., Trinity, '90, P. & S., N. Y., '94, Hartford.  
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- McCann, D. J., Holy Cross, '30, Tufts, '34, Hartford.  
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 McCullough, E. A., A.B., Bowdoin, '90, Harvard, '94, Meriden.  
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 McDermott, T. S., Yale, '98, Westbrook.  
 McDonnell, R. E., B.A., Yale, '17, Yale, '20, New Haven.  
 McFarland, F. W., B.A., Univ. Vt., '25, Univ. Vt., '28, Stamford.  
 McGaughey, J. D., Jefferson, '10, Wallingford.  
 McGourty, A. F., N. Y. Homeo., '18, Stamford.  
 McGourty, D. P., B.S., N. Y. U., '27, Jefferson, '27, Stamford.  
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 McGrath, J. H., Yale, '08, Waterbury.  
 McGuire, W. C., Yale, '09, New Haven.  
 McHugh, J. F., Harvard, '01, Thompsonville.  
 McLroy, P. T., Queen's, '21, New Canaan.  
 McIntosh, E. F., Yale, '97, New Haven.  
 McLarney, T. J., P. & S., Balt., '97, Waterbury.  
 McLaughlin, J. H., P. & S., Balt., '09, Jewett City.  
 McLean, J. C. J., Tufts, '20, Hartford.  
 McLean, T. S., B.S., Vt., '34, Bridgeport.  
 McLellan, P. G., B.A., Bowdoin, '21, Harvard, '25, Hartford.  
 McMahon, F. C., Fordham, '19, Stamford.  
 McMahon, G. W., Tufts, '37, A. B., Georgetown, '30, New Britain.  
 McMahon, W. H., Jr., Fordham, '20, South Norwalk.  
 McManus, J. P., P. & S., Balt., '14, Bridgeport.  
 McNulty, T. F., Georgetown, '32, Hartford.  
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 McPherson, S. H., Tufts, '13, Hartford.  
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 McQueeney, A. M., Yale, '05, Bridgeport.  
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 Meade, C. H. B., Louisville U., '02, Stamford.  
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 O'Connor, D. S., Bowdoin, '19, New Haven.  
 Oelschlegel, H. C., Jefferson, '11, Torrington.  
 Oeseau, H. T., Jefferson, '26, Stratford.  
 O'Flaherty, E. P., Cornell, '01, Hartford.  
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 Ogden, R. T., B.A., Bowdoin, '21, Harvard, '24, Hartford.  
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 Otis, I. S., Geo. Wash., '17, Meriden.  
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 Parker, T. E., Yale, '04, Waterbury.  
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 Pasuth, B. C., Univ. Md., '16, Bridgeport.  
 Patterson, D. C., P. & S., Balt., '06, Bridgeport.  
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 Pepe, C. T., B.A., Yale, '19, Hahn, Chicago, '22, Derby.  
 Perdue, R. E., Starling, '95, Norwalk.  
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 Perkins, C. W., Hahn., Phila., '01, Norwalk.  
 Perreault, J. N., Tufts, '07, Danielson.  
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 Phelps, M. O., B.S., McGill, '25, McGill, '29, Hartford.  
 Phelps, P. S., McGill, '30, Hartford.  
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- Robbins, C. L., Yale, '29, New Haven.
- Roberts, D. J., Univ. Vt., '16, Hartford.
- Roberts, E. R., Med. Sch. Me., '13, Bridgeport.
- Roberts, F. W., Johns Hopkins, '24, New Haven.
- Robinson, A. J., Toronto U., '23, Hartford.
- Robinson, W. J. T., L. I. Coll. Hosp., '21, Broad Brook.
- Roccapriore, B. A., Niagara, Jefferson, '31, Middletown.
- Roch, G. E., B.A., Holy Cross, '30, Tufts, '34, Willimantic.
- Roche, A. F., B.S., Georgetown, '15, Georgetown, '17, Hartford.
- Roche, T. J., P. & S., Balt., '11, Bridgeport.
- Rockwell, A. E., Johns Hopkins, '21, Bridgeport.
- Rogers, F. P., Syracuse Univ., '33, Hartford.
- Rogers, O. F., Jr., B.A., Harvard, '08, Harvard, '12, New Haven.
- Rogers, P. H., Yale, '12, West Haven.
- Rogers, R. P., B.A., Harvard, '21, Harvard, '25, Greenwich.
- Rogol, L., B.S., Yale, '29, L. I. Coll., '33, Danbury.
- Rogol, O., Ph.B., Brown, '20, Dalhousie, '32, Seymour.
- Rogowski, B. A., Ph.B., Yale, '20, New Haven.
- Rollins, H. B., B.S., Dartmouth, '20, Yale, '22, Hartford.
- Romaniello, R. J., B.A., Holy Cross, '23, P. & S., N. Y., '27, Hartford.
- Rooney, J. F., Balt. Med., '03, Hartford.
- Root, J. H., Ph.B., Harvard, '18, Waterbury.
- Root, M. T., B.A., Cornell, '15, Cornell, '18, West Hartford.
- Root, S. Q., Wom. Med. Homeo., N. Y., '96, Stamford.
- Root, S. T. A., B.A., Barnard, '14, M.A., Columbia, '15, Cornell, '19, West Hartford.
- Rose, S. A., N. Y. U. & Bell., '23, Stamford.
- Rosenbaum, G. J., B.S., Trinity, '30, Tufts, '34, Hartford.
- Rosenthal, E., Univ. of Wurtenburg & Munich, '24, Hartford.
- Rosenthal, I., L. I. Coll., '10, South Norwalk.
- Roth, F. E., Univ. & Bellevue, '25, Hartford.
- Rothblatt, R., Tufts, '32, A.B., Harvard, '37, Willimantic.
- Rothschild, M. L., Ph.B., Yale, '19, Paris U., '26, New Haven.
- Rowe, M. J., P. & S., Balt., '96, Bridgeport.
- Rowell, E. E., Hahneman, '99, Stamford.
- Rowley, A. M., Univ. Vt., '97, Hartford.
- Rowley, J. C., B.A., Harvard, '02, Harvard, '06, Hartford.
- Rowley, R. L., Yale, '03, Hartford.
- Roy, J. L., B.A., Clark, '30, Tufts, '34, North Grosvenordale.
- Rubin, G. A., Edinburgh, '32, New Haven.
- Ruby, M. H., Ph.B., Yale, '18, P. & S., N. Y., '21, Waterbury.
- Ruby, R. J., Baylor, '36, Waterbury.
- Russell, E. F., B.A., Yale, '16, Cornell, '20, Santa Barbara, Cal. (New Haven Co.).
- Russell, G. G., B.A., Harvard, Harvard, '19, Hartford.
- Russell, J. J., N. Y., Homeo., '87, Putnam.
- Russell, T. H., Ph.B., Yale, '06, Yale, '10, New Haven.
- Russell, W. I., Yale, '09, New Haven.
- Russmann, C., Tufts, '23, Middletown.
- Russo, J. D., Ph.B., Yale, '12, Yale, '16, New Haven.
- Ryan, F. J., B.S., Trinity, '30, Tufts, '35, Hartford.
- Ryan, T. M., B.A., Loyola Coll. Balt. Med., '02, Torrington.
- Ryder, R. H., P. & S., Balt., '13, Waterbury.
- Ryder, W. H., Jefferson, '20, New Haven.
- Rynard, W. M. W., Toronto U., '24, Stamford.
- Salinger, R., Johns Hopkins, '25, New Haven.
- Salmond, P. H., Univ. Manitoba, '20, North Battleford (Fairfield Co.).
- Salvin, B. L., Geo. Wash., '21, Hartford.
- Samponaro, N., B.S., Trinity, '25, Johns Hopkins, '29, Hartford.
- Sanderson, R. V., Univ. Vt., '20, Winsted.
- Sandulji, G. R., B.A., Harvard, '25, Tufts, '29, Waterbury.
- Sanford, C. E., Yale, '06, New Haven.
- Santoro, G. M., B.A., Cornell, '24, Waterbury.
- Satti, C. J., Yale, '23, New London.
- Savarese, M. F. R., L. I. College of Med., '11, New Haven.
- Sayers, D. O'C., B.S., Conn. State, '31, Tufts, '35, Waterbury.
- Sayers, J. J., B.S., Trinity, '30, Tufts, '35, Hartford.
- Scafarello, P. J., Tufts, '26, Hartford.
- Scanlon, J. J., B.S., Georgetown, Georgetown, '35, South Norwalk.
- Scanlon, T. F., Yale, '07, Norwalk.
- Scarborough, M. McR., B.A., Univ. Oregon, '02; M.A., Yale, '05, Yale, '07, New Haven.
- Schaefer, A. M., Ph.B., Yale, '21, Yale, '25, Hartford.
- Schaefer, J., Tufts, '17, Hartford.
- Schechtman, C. T., Univ. Vt., '26, New Britain.
- Schiavetti, A., B.A., Columbia, '26, Tufts, '30, Stafford Springs.
- Schmidt, N. L., B.S., Yale, Vanderbilt, '27, Stamford.
- Schneider, W., B.S., N. Y. U., '27; B.S. (Med.) Univ. Kan., '28, Geo. Wash., '30, Rockville.
- Scholl, R. F., Yale, '12, New Haven.
- Schuman, D. H., B.S., Columbia, '20, P. & S., N. Y., '22, Hartford.
- Schupack, S. D., Tufts, '24, New Britain.
- Schwartz, P. E., Tufts, '31, Portland.
- Scott, C. R., B.S., Westminster, '15, Yale, '19, New Haven.
- Scott, J. C., B.S., Haverford, '29, U. of Penn., '33, Essex.
- Scott, W. J., Fordham, '16, Derby.
- Scoville, D. H., Cinn. U., '30, New London.
- Sculder, W. D., Harvard, '20, Hartford.
- Scully, R. T., Fordham, '30, Georgetown, '35, New Britain.
- Seabury, R. B., Harvard, '18, New Haven.
- Sears, L., Harvard, '29, Norwich.
- Segel, S., B.S., Vermont, '31, Vermont, '35, Norwich.
- Segnalla, E., Yale, '12, New Haven.
- Segur, G. C., P. & S., N. Y., '82, Hartford.
- Seibert, A. F., Yale, '27, Hartford.
- Seigall, H. A., Univ. Vt., '14, Hartford.
- Sekerak, A. J., Univ. Md., '22, Bridgeport.
- Sekerak, R. A., Maryland, '29, Bridgeport.
- Sekerak, R. J., Maryland, '34, Bridgeport.
- Selinger, J., Georgetown, '13, New Canaan.
- Selleck, N. B., L. I. Coll. Hosp., '24, Danbury.
- Sellew, R. C., Yale, '98, Canaan.
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- Serrell, H. P., B.S., Dartmouth, '28, Cornell, '32, Greenwich.
- Sette, A. J., Geo. Wash., '27, Stamford.
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- Sharp, L. I., McGill, '35, B.S., McGill, '31, Hartford.
- Shaw, G. H., Syracuse, U., '08, Hartford.
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- Shea, C. J., Maryland, '33, Bridgeport.
- Shea, D. E., Loyola, '17, Hartford.
- Shea, J. F., P. & S., Balt., '11, Bridgeport.
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- Shea, R. E., Yale, '30, Willimantic.
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- Shea, V. T., Tufts, '31, Waterbury.
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- Shirk, S. M., Hahn, Phila., '97, Stamford.
- Shockley, F. M., Univ. Med. Coll. Kansas C., '13, Stamford.
- Shulman, D. N., B.A., Johns Hopkins, '13, Johns Hopkins, '17, Hartford.
- Shure, A. L., Tufts, '27, New Haven.
- Sigal, J. B., B.S., Trinity, '19, Yale, '23, Hartford.
- Sikes, R. F., B.A., Yale, '31, Yale, '35, Westbrook.
- Siliciano, R. A. V., Hahn, Chicago, '24, Bristol.
- Sills, T. H., B.S., Yale, '24, Yale, '27, Newington.
- Silverberg, S. J., P. & S., N. Y., '21, New Haven.
- Simmons, E. M., B.A., Bowdoin, '19, Yale, '23, Southington.
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- Simonton, F. F., Med. Sch. Me., '03, Thompsonville.
- Skiff, S. E., Hahn, Phila., '03, New Haven.
- Skinner, C. E., LL.D., Rutherford, '01, Yale, '91, New York City & Darien (New Haven Co.).
- Slater, M., Ph.B., Yale, '19, Yale, '24, Hamden.
- Slavin, J. E., Vermont, '31, Tufts, '35, Waterbury.
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- Slysz, L. B., Boston U., '27, New Britain.  
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 Smith, H. B., M.P.H., Harvard, '31, Univ. Pa., '26, Marianna, Florida.  
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 Smith, M., U. City N. Y., '83, New Haven.  
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 Smith, S. M., Tufts, '20, Greens Farms.  
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 Smith, V. J., Univ. Pa., '20, New Britain.  
 Smith, W. B., Univ. Pa., '22, Wethersfield.  
 Smith, W. E., Univ. Mich., '10, Stamford.  
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 Snelling, P. W., B.A., Univ. Ga., '17, Harvard, '21, Hartford.  
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 Solomon, C. I., B.S., C. City N. Y., '21, Yale, '25, Meriden.  
 Soltz, T., Jefferson, '11, New London.  
 Soper, W. B., B.A., Yale, P. & S., N. Y., '08, West Haven.  
 Soreff, L., B.S., Tufts, '28, Tufts, '32, East Hampton.  
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 Spector, N., B.S., Tufts, Tufts, '24, Lynn, Mass. (Windham Co.).  
 Speight, H. E., Georgetown, '27, Middletown.  
 Speir, E. B., B.A., Kansas, '29, Kansas U., '33, New Haven.  
 Spekter, L., Trinity, '29, Univ. Roch., '33, Hartford.  
 Sperandeo, A., Ph.B., Yale, '21, Yale, '25, New Haven.  
 Sperry, F. N., Yale, '94, New Haven.  
 Spicer, E., Yale, '05, Waterbury.  
 Spillane, B., B.A., Dartmouth, '13, Tufts, '16, Hartford.  
 Sprague, C. H., P. & S., N. Y., '04, Bridgeport.  
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 Stahl, W. M., Univ. Md., '14, Danbury.  
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 Standish, F. B., Yale, '03, New Haven.  
 Standish, H. C., Cornell, '28, Hartford.  
 Standish, J. H., U. City N. Y., '95, Hartford.  
 Standish, W. A., B.A., Yale, '22, Yale, '25, Hartford.  
 Staneslow, J. S., B.A., Cornell, '22, Cornell, '26, Waterbury.  
 Starr, R. M., B.S., Mich. State, '17, Yale, '26, New London.  
 Starr, R. S., B.A., Trinity, '97; M.A., Trinity, '00, P. & S., N. Y., '01, Hartford.  
 Starrett, J. E., B.S., Univ. N. H., '26, Tufts, '30, Stamford.  
 Staub, J. H., L. I. Coll. Hosp., '99, Stamford.  
 Stein, A., Univ. Md., '17, Thompsonville.  
 Steincrohn, P. J., Univ. Md., '23, Hartford.  
 Steiner, W. R., B.A., Yale, '92; M.A., Yale, '95; L.H.D., Trinity, '31, Johns Hopkins, '98, Hartford.  
 Stempa, H., Berlin U., '98, Hartford.  
 Stephenson, C. W., Harvard, '22, Hartford.  
 Stetson, H. W., Univ. Vt., '06, Milford.  
 Stettbacher, H. J., B.S., Bates, '17, Harvard, '22, Waterbury.  
 Steudel, H., Univ. Kiel, '89, Ansonia.  
 Stevens, H. G., Maryland, '04, New Milford.  
 Stevens, M. A., Yale, '29, New Haven.  
 Stevenson, W. R., Boston U., '31, Bristol.  
 Stewart, H. E., Yale, '10, New Haven.  
 Stewart, L. Q., B.S., Middlebury, '26, Yale, '33, West Hartford.  
 Stietzel, E. E., B.S., Yale, '30, Columbia, '34, South Norwalk.  
 St. John, L. A., Fordham, '20, Hartford.  
 Stockwell, W. M., Univ. Pa., '04, Hartford.  
 Stolzheise, R. M., A.B., Willemette, '26, Univ. Oregon, '34, Hartford.  
 Stone, E. L., B.A., Williams, '16, Johns Hopkins, '20, New Haven.  
 Stone, H. R., Wesleyan, '99, Johns Hopkins, '04, Clinton.  
 Stone, M. J., B.S., Chicago, Rush, '22, Stamford.  
 Stone, W. S., P. & S., N. Y., '91, Norwalk.  
 Storms, W. F., Ph.B., Brown, '26, Harvard, '30, Wethersfield.  
 Storrs, E. R., Jefferson, '00, Hartford.  
 Storrs, R. W., B.S., Trinity, '17, Harvard, '20, Hartford.  
 Stoughton, D. H., McGill, '18, Hartford.  
 Stratton, E. A., U. City N. Y., '83, Danbury.  
 Strauss, M. J., B.A., Yale, '14, P. & S., N. Y., '17, New Haven.  
 Strayer, E. M., A.B., B.D., Baylor, '24, Columbia, '33, Stratford.  
 Strayer, L. M., Jr., B.A., Princeton, '26, Harvard, '30, Stratford.  
 Streit, G., Yale, '01, New Haven.  
 Stretch, J. E., Geo. Wash., '28, Simsbury.  
 Strickland, H., McGill, '30, Meriden.  
 Stringfield, O. L., B.S., Wake Forest Coll., N. C., Univ. & Bellevue, '16, Stamford.  
 Strobel, J. E., Temple, '09, Greenwich.  
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 Sullivan, D., N. Y. U., '97, New London.  
 Sullivan, J. F., B.A., Yale, '90, P. & S., N. Y., '94, New Haven.  
 Sullivan, T. J., B.A., Yale, '15, Yale, '17, New Haven.  
 Sunderland, P. U., N. Y. Homeo, '94, Danbury.  
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 Sussler, D., Fordham, '16, Norwich.  
 Sutherland, F. A., B.A., W. & L., '22, Harvard, '26, Torrington.  
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 Tait, A. A., Carthage, '24, Univ. Ill., '27, Univ. Penn., '36, Univ. Ill., '30, West Hartford.  
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 Tanner, M. J., Tufts, '18, New Haven.  
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 Taylor, M. W., Tufts, '05, Hartford.  
 Taylor, R. M., B.A., Geo. Wash., '19, Geo. Wash., '22, East Haven.  
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 Teele, J. E., B.A., Tabor, '85, Wom. Med., Pa., '88, Greens Farms (New Haven Co.).  
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 Thalberg, R. E., B.S., Yale, '23, Yale, '26, Southington.  
 Thayer, R. B., B.S., Bowdoin, '17, Bowdoin, '20, Somers.  
 Thenebe, C. L., Univ. Pa., '18, Hartford.  
 Thomas, J. J., Fordham, '21, Ansonia.  
 Thompson, C. G., N. Y. Homeo, '18, Norwich.  
 Thompson, H. G., B.A., Yale, '13, Harvard, '17, Hartford.  
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 Thompson, L. E., Boston U., '25, Waterford.  
 Thompson, L. J., Univ. Mo., '19, Wash. U., '19, New Haven.  
 Thompson, S. A., B.A., Wes., '18, Cornell, '23, Greenwich.  
 Thoms, H., Yale, '10, New Haven.  
 Thomson, T. L., B.A., Princeton, '98, Hahn., Phila., '01, Torrington.  
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 Tinkess, D. E., McGill, '25, Greenwich.  
 Tirella, F. F., Tufts, '37, Bristol.  
 Todd, F. P., Boston U. (Homeo.), '89, Danielson.  
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 Tortolani, A. P., A.B., Brown, '29, C. M., McGill, '34, Plainville.  
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 Tuttle, A. L., Albany Med., '88, Lakeville.  
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 Vernlund, C. F., B.S., S. Dak. State, '09, Harvard, '14, Hartford.  
 Vernon, S., B.S., C. City N. Y., L. I. Coll. Hosp., '30, Willimantic.  
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In a world which is becoming more and more machine-made and mechanized, in which the individual tends to become more and more swamped in the mass, it seems to me a good thing, indeed an imperative duty, whenever we can, to keep our profession, and the rights and privileges and welfare of the individual, free from the shackles of standardization — a condition which is the inevitable result of Government control. Nowhere is such an effort so necessary as in those countries which profess to believe in freedom of thought and action, and dislike the growth of the authoritarian idea.

The proper function of the State so far as the actual provision of medical attendance is concerned, is to leave it as far as possible to a free profession dealing with a free people; to encourage the profession and people to make voluntary arrangements where practicable, preferably on an insurance basis; to make such arrangements compulsory where the voluntary principle does not work; to aid financially those citizens who

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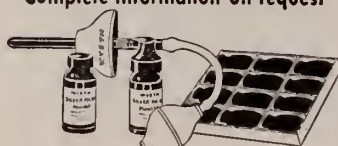


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cannot provide entirely for themselves; and to keep the "dead hand" of officialdom as far off as possible. I want to make progress without impairing some of the most precious gifts possessed by the ordinary man, namely, the desire to help himself, to be independent, and to be regarded, not as a mere cog in the State machine, but as a self-respecting and, so far as possible, a self-maintaining citizen. In this way of approach I believe we shall not only be doing the best we can for our potential patients and for our profession — which can only operate to its maximum capacity as a *free* profession — but also for the community as a whole, by making it clear that in the field of medicine we desire to minimize State control because it is likely to officialize our profession and consequently lessen its usefulness to the individuals who form the community.

The best plan would be like the State Medicine Scheme, a salaried service, and, like the Insurance Scheme, it will embody the principle of free choice; but much more than either it will ensure that purely medical administration is

left in the hands of the medical profession.

A State Medical Service is not only inevitable but desirable. At the same time the ideal should be to ensure that every case of illness is seen in the first instance in the patient's own home by his own family doctor. Only thus could factors, psychological, hereditary and environmental, having an important bearing on diagnosis and treatment, be observed.

The importance of free choice of doctor is overstressed. Choice is in any case usually fairly limited, and proximity probably exerts more influence than anything else in the making of a selection for the first time. Once a choice has been made patients will, however, go to a great deal of trouble to keep their own doctor.

Under a State Medical Service the "high-spots" might not be so high as under the fierce competition of private practice; but the "low-spots" would certainly never be allowed to be so low and I think the average standard of medical practice would be a good deal higher than it is at present.

*Pro. Royal Soc. Med., London, May 1939*



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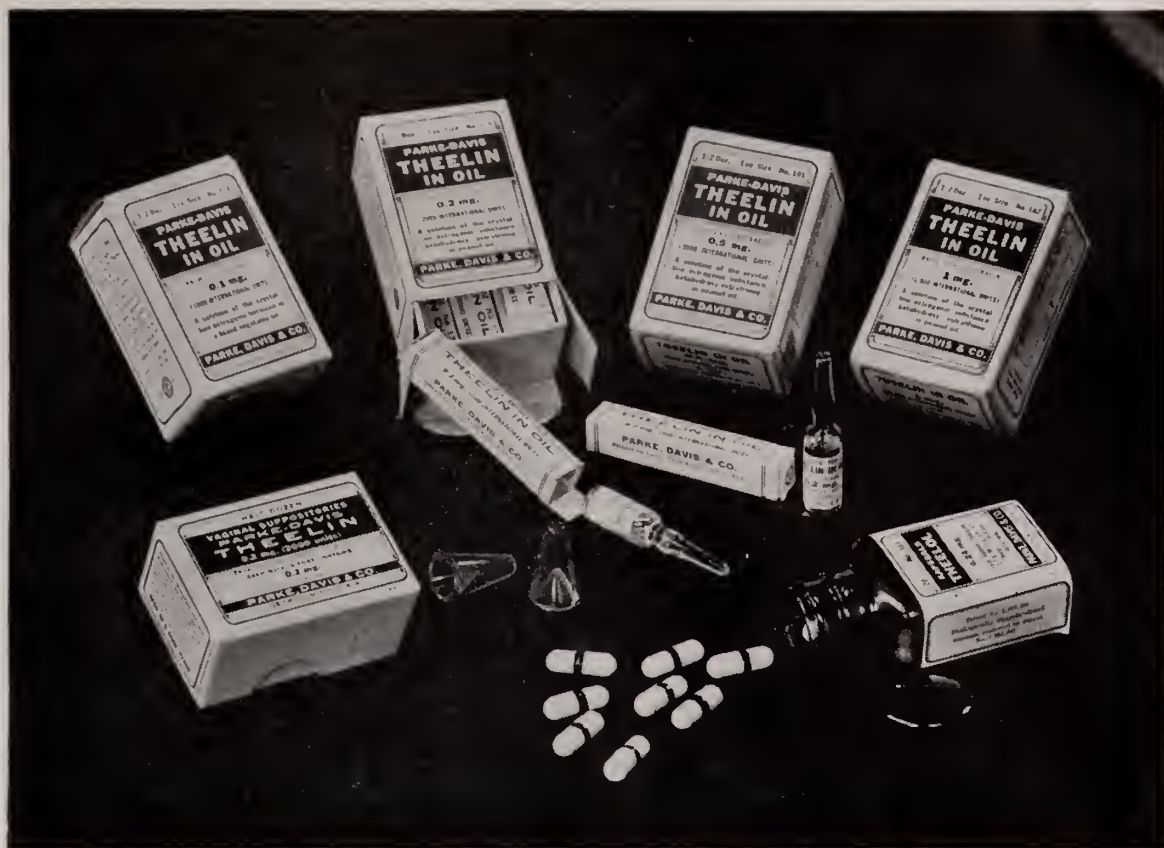
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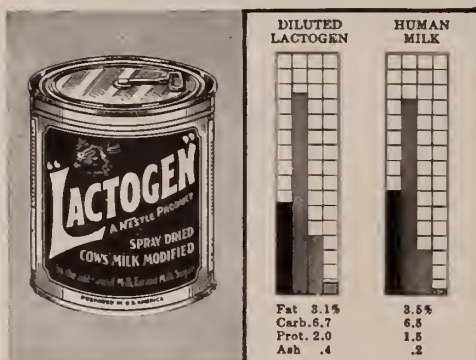
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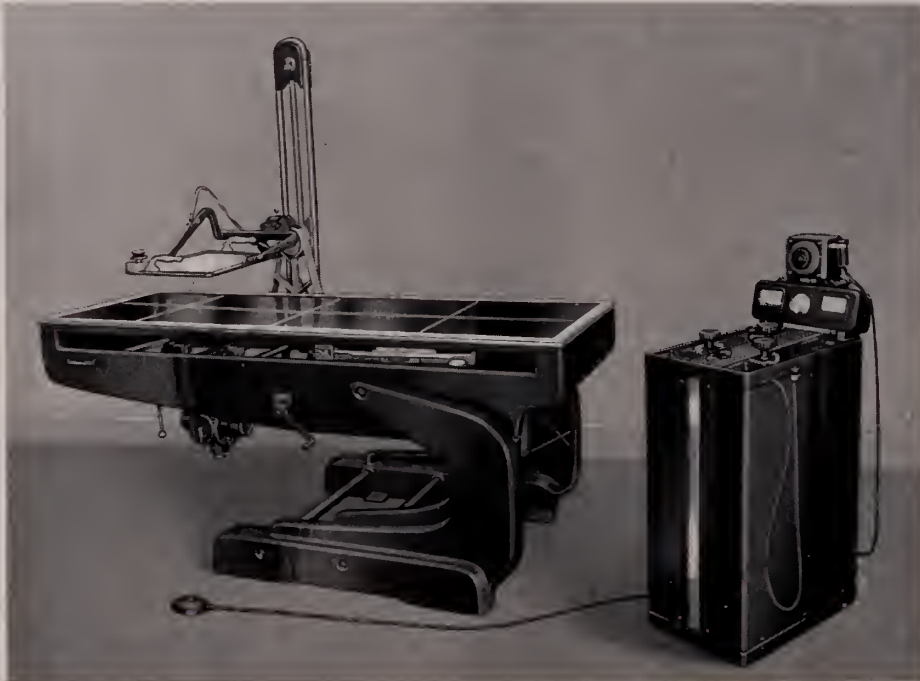
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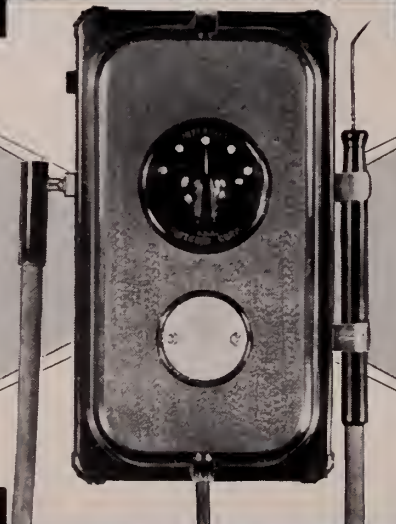
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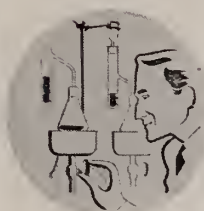
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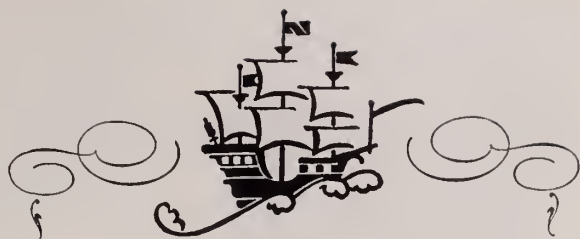
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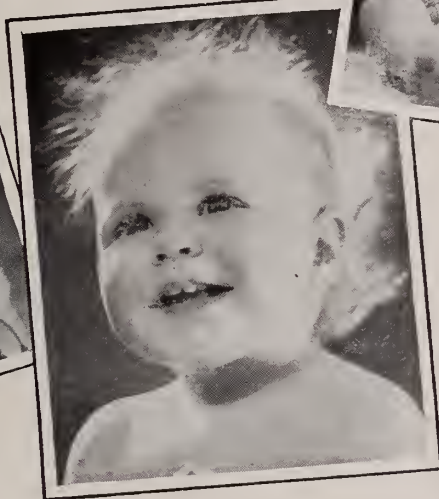
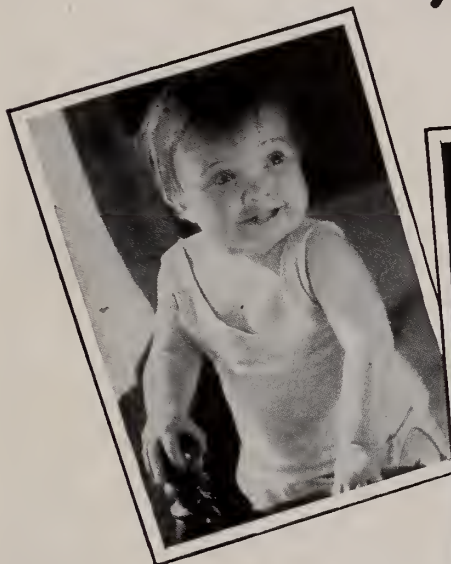
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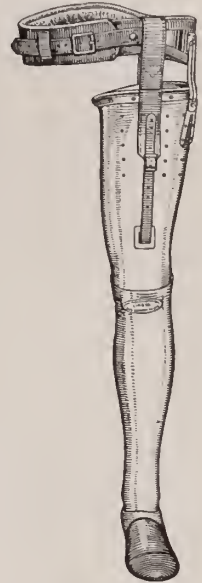
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# JOURNAL *of* The Connecticut State Medical Society

VOL. III.

SEPTEMBER, 1939

No. 9

## The Treatment of Burns\*

ROY D. McCLURE, M.D.,†  
Detroit, Michigan

In discussing the subject of the treatment of burns, it is impossible to avoid frequent mention of two investigators who labored diligently on this problem. Many of you knew one of them well, as a biochemist, pharmacologist and scientist. I refer, of course, to the late Dr. Frank P. Underhill, of the Yale School of Medicine. The other investigator was well known to me, for it was during his service as resident surgeon at the Henry Ford Hospital that Dr. E. C. Davidson did his work on the tannic acid method of treatment. Davidson's first paper<sup>1</sup> created a tremendous interest in burns, as indicated by the fact that in the next ten years, there appeared 465 papers on burns, as compared with 174 in the preceding ten years.

I have indicated that my subject is "the treatment of burns" rather than "the tannic acid treatment of burns", for the local treatment of the skin by this or any other method is only a small part of the treatment<sup>2</sup>. Vigorous general measures must be employed if lives are to be saved.

The clinical course of severe burns is commonly divided into the following phases: (1) Primary shock, (2) the so-called toxemic phase, (3) Sepsis (if it occurs) and (4) healing. The stages of late sepsis and healing are really special problems in wound healing, and will not be discussed at length.

Primary shock occurs immediately after the injury, and is usually over by the time the burned individual reaches the hospital. In all probability, it is due to pain and fright; hence it is of nervous origin. It is indistinguishable from

the primary shock resulting from other forms of trauma. The treatment is the same as that given for other forms of surgical shock, namely, adequate sedation, stimulants, raising foot of bed, application of external heat, and immediate transfusion, if the shock is severe. This type of shock has been no problem, since it has been observed very infrequently. This has been the experience of others, such as Wilson and his co-workers<sup>3</sup> in Great Britain, who observed severe shock in only 2 out of 65 seriously burned patients.

After the primary shock has been ruled out or treated if present, we may proceed to the local treatment. In a very warm room, remnants of clothing or first aid dressings are removed as quickly and carefully as possible. It must be constantly borne in mind that the burned area should be treated as a large surgical wound, very susceptible to infection. Our house officers are instructed to wear gowns, gloves, and masks while handling the patients in the early hours. The patient is then transferred to a "burn bed" which has been prepared with sterile sheets. A measure of debridement is then done. This consists only of opening blisters and removing tags of epidermis.

The local application of an eschar-forming chemical is then begun. At the Henry Ford Hospital, we have continued to use tannic acid for this purpose. A freshly prepared 5 per cent solution is sprayed on the burned areas by means of an atomizer, at frequent intervals, until a satisfactory crust is obtained. Usually, a tough eschar is present after twelve hours. Recently,

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we have found it convenient to apply the tannic acid in the madium of a water-soluble jelly, to which has been added an antiseptic of the resorcinol group (Hexyl-chloro-resorcinol). Several applications of the jelly over a 12-18 hour period produce a good crust. The jelly is convenient because the compound is stable, and does not have to be freshly prepared. It is particularly useful in burns about the face and perineum. Our Divisions of Ophthalmology is using this preparation with good results in burns involving the cornea.

Several variations in this technique have been suggested. Fantus and Dyniewicz<sup>1</sup> added different tannic acid solutions to defibrinated dog's blood, and noted the completeness of precipitation. They concluded that a 10 per cent solution was the most efficient protein precipitant, Ringer's solution was the best vehicle, and a pH of 3.22 was desirable. They felt that 1:1000 salicylic acid was a good antiseptic, and did not interfere with the precipitation. On the basis of these studies, they suggested a formula for a "compound solution of tannic acid," and reported success with its use at the Cook County Hospital.

Bettman<sup>5</sup> has had excellent results with a combined tannic-acid-silver nitrate treatment. The burned area is sprayed with 5 per cent tannic acid, followed immediately by 10 per cent silver nitrate. A coagulum is formed immediately. Meyer and Wilkey<sup>6</sup> reported that 220 cases were treated by this method at the Cook County Hospital, with a mortality of 8.6 per cent. Eighteen cases were infected.

Aldrich<sup>7</sup> believed that infection with beta hemolytic streptococci was the determinant factor in burn results, and because of its specificity for the gram positive cocci, advised the use of gentian violet. Subsequently<sup>8</sup>, he advocated a mixture of brilliant green and neutral acriflavine.

After one of the above tanning methods is begun, the body is covered with a cradle and sheets, if the trunk and lower extremities are involved. The tent is heated with the necessary number of bedside lamps to maintain a bed temperature of 90°-F. The lamps keep the patient comfortable without the usual bed clothes, combat shock, and hasten the tanning process. Nursing care is simplified.

The local treatment of the skin has been discussed first because it comes first chronologically,

but it is not as important as the general measures that will be considered now, measures which are calculated to combat the serious symptoms which arise 18 to 24 hours after the burn. This is the so-called toxemic phase, and it is a familiar and disheartening sight to those who treat severe burns. In a typical fatal case, the patient appears to be doing well, the skin has been nicely tanned, fluids are being tolerated, and the mind is alert. During the second day, a more or less sudden change for the worse takes place. Adults become anxious, children become apathetic and stuporous. Pulse and temperature go up. Vomiting occurs, and the vomitus usually contains brown material or gross blood. Toward the end, the sclerae may become icteric. The respirations become rapid, coma and fall in blood pressure indicate impending exitus.

The cause of the above picture is not definitely known. For this reason, all reasonable possibilities must be considered, and our treatment of this phase must be somewhat of the nature of a "shotgun prescription." There are three main theories regarding the so-called toxic phase.

#### Bacterial Theory

A few investigators believe that the fatal factor in burns is due to infection with streptococci. This theory has been championed by Aldrich, who at the suggestion of Firor, took cultures of burns at various stages. He found a close correlation between the degree of infection with the beta hemolytic streptococcus and the degree of toxemia. His work has not been corroborated. At the Henry Ford Hospital, we have not often found evidence of infection under the crusts or in the blood stream of fatal cases. Another typical report is that of Wilson and his co-workers, who studied 200 burns, 65 of which were serious, and 20 of which came to autopsy. Aerobic and anaerobic cultures were taken. They stated, "Certainly there was rarely any evidence that hemolytic streptococci were flourishing in the burned area and invading the blood stream. Moreover, hemolytic streptococci were sometimes grown in pure culture from isolated portions where systemic disturbances were absent."

I do not wish to belittle the infectious factor in burns. There is no question but that burns become infected when proper early antiseptic treatment is delayed. But such infection is more apt to appear after a week or ten days. We recently had a fatality due to a septic thrombo-phlebitis

and septicemia following a burn of the hands and face. However, this man died three weeks after the injury. The treatment of burns should include measures against infection, the most important of which is scrupulous aseptic technic in the early treatment. As previously stated, we have added an antiseptic of the resorcinol group to the tannic acid, which Hartman and Shelling<sup>9</sup> synthesized after showing the efficient bactericidal power of such a combination, and the lack of toxicity to cells in tissue culture.

### Plasma Loss Theory

A more popular theory states that there is great loss of plasma locally, at the site of the burn, and perhaps generally to some extent, as a result of increased capillary permeability. This results in a rise of the hemoglobin. It is not proper to speak of this change as hemo-concentrations, because not all of blood constituents are concentrated. On the contrary, the plasma proteins are frequently depleted, especially if there has been vigorous administration of intravenous saline. Underhill<sup>10</sup> called attention to this phenomenon in 1923, and further work has been done by Blalock and his associates<sup>11</sup>, Harkins<sup>12</sup>, and others.

The therapeutic measure to combat this plasma loss is obvious — prompt and frequent plasma transfusions. This treatment must be begun at once, and it is not wise to wait until laboratory determinations of plasma proteins show a significant fall.

### Toxic Theory

The third theory is that a toxic substance is formed at the site of the burn, and this is carried in the blood to other parts of the body, with the production of severe systemic disturbances. In his recent excellent review of the literature on burns, Harkins<sup>13</sup> tabulates 20 substances which have been postulated as the toxins of burns. This is an old theory, but it received a serious set-back when Underhill and his associates<sup>14</sup> showed that the toxic factor in the burned tissue extracts of previous investigators (Boyd and Robertson<sup>15</sup>) was really the ethyl alcohol used in the extraction process. They showed that there was poor absorption of strychnine and other substances from the burned tissues.<sup>16</sup>

Recently, further evidence favoring the toxic theory has accumulated. Mason and his co-workers<sup>17</sup> have demonstrated ample absorption of certain substances, such as potassium iodide,

from burned areas. Wilson and others<sup>18</sup> found that the tissue juices near a burn were toxic to healthy animals. Rosenthal<sup>19</sup> of the University of Illinois demonstrated the presence of a histamine-like substance in the blood of burned animals and humans, which was not present in the controls.

The newer knowledge of the pathology of burns favors the theory of a circulating toxin. A vulnerable organ is the liver. Hepatitis of varying degrees is frequently observed in fatal burns. We have seen cases where the liver lesion alone was sufficient to explain the death of the patient. We recently treated a man with 25 per cent of the body surface burned. Jaundice appeared on the fifth day, and the icterus index reached 130 units. After studying 20 autopsies on burned patients, Wilson stated, "In summary, we may say that after death from burns, a lesion of the liver cells was found in many cases which was characteristic of this form of injury. Its relation to acute toxemia was so remarkably close as to leave little doubt that the liver lesion and the acute toxemia were produced by the same mechanism. The responsible agency was certainly not bacterial infection, and in our view, the liver lesion furnished the strongest indication of a non-bacterial toxin circulating during the first few days after a burn."

In 1937, I discussed the tannic acid treatment of burns at the French Surgical Congress<sup>20</sup>. Representatives from several nations felt that at the present time, the evidence is in favor of the presence of a soluble toxin.

If we admit the possibility of a burn toxin, what significance has this with regard to treatment? In the first place, the conversion of as much burned tissue as possible into an inert crust is a step in the right direction. This was Davidson's original plan. Experience has shown, however, that the local treatment of the skin does not protect completely against the supposed toxemia. It would appear to be logical to attempt to dilute the hypothetical toxin with adequate fluids, using blood plasma generously. Urinary output should be kept up to an adequate level. According to Collier and Maddock,<sup>21</sup> there should be a daily output of 1500 cc for an adult surgical patient. However, there may be danger of over-treating with fluids, for the work of Minot and Dodd<sup>22</sup> suggests that blood proteins are washed out of the wounded area by dilution



with normal saline and glucose solution. Plasma transfusions are much better than whole blood if there is a high hemoglobin concentration and also if the plasma proteins are low. Venesection followed by transfusion has again been suggested. A recent report from Germany<sup>21</sup> describes a case of an infant with more than 50 per cent of the body surface burned. Judging from the picture accompanying the article, this child would probably have died under ordinary forms of treatment. Numerous venesections and transfusions were done, and the child recovered. Since hepatitis is a frequent complication, glucose therapy is theoretically indicated, to fortify the liver and aid in regeneration. Many authors have reported changes in the adrenals in autopsies of persons dying of burns, and it has been suggested that this pathologic change may have something to do with the circulatory failure in the terminal stage of burns. Therefore, it would be reasonable to administer adrenal extract (cortin) in selected cases.

#### After Care

If the patient survives the first week, he is almost certain to get well. Glover<sup>22</sup> has placed the odds for recovery as 10 to 1 on the first day, 25 to 1 on the third day, and 100 to 1 on the seventh day. Therefore, after the first week, we cease to worry about the patient's life, and give attention to the cosmetic and functional result. Burns on the flexor surfaces should receive special attention to prevent the development of contractures. Proper splinting and early skin grafting will prevent such deformities. Penberthy and Weller<sup>23</sup> at the Children's Hospital in Detroit observed so many deformities in children, and made a plea for more careful treatment of these cases by physicians.

If the skin has been treated with tannic acid, the coagulum will begin to curl after two weeks, and portions of it can be removed, revealing the healed epithelium beneath. If granulating areas of considerable size remain, they should be grafted immediately. The ordinary Reverdin or pinch graft is best for this purpose.

There is need for preventive medicine in the field of burns. There were almost 8000 deaths from fire in the United States in 1937.<sup>24</sup> Penberthy<sup>25</sup> states that 45 per cent of lethal burns are in children, and in his series of 493 cases at the Children's Hospital, there were 398 (80 per

cent) avoidable accidents. Another 10 per cent could not be classified with regard to avoidability; thus only 10 per cent could be considered unavoidable. Physicians should caution mothers about the dangers of proximity of children to hot beverages near the edge of the table, open fire of all kinds matches, and scalding water in buckets or tubs. Physicians entrusted with the safety of laborers in industry should guard unceasingly against fire hazards. In burns, an ounce of prevention is worth many tons of cure.

#### Summary

The present status of the treatment of burns has been outlined. For the treatment of the skin, the use of tannic acid has been recommended, although it is admitted that the use of other eschar-forming chemicals gives satisfactory results. Particular stress has been placed on the need for surgical asepsis during the treatment. It has also been indicated that the local treatment of the skin is not as important as the treatment of the patient as a whole. The value of plasma transfusions has been emphasized. In order to rationalize the general treatment, it has been necessary to review some of the theories which seek to explain the alarming symptoms which appear in 18 to 24 hours after a severe burn. It has been admitted that several factors may be important, and that to a reasonable extent, treatment should be directed against all of these factors.

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## MORTALITY EXPERIENCE OF THE FIRST SIX MONTHS OF 1939

Despite the high prevalence of influenza and the respiratory diseases during the winter months 1939 has since been developing into one of the best health years in the country's history. In fact, if there are no untoward circumstances during the second half of the year, the mortality rate for the full year 1939 will be lower, with a single exception, than ever before recorded.

Data from several sources point to this conclusion. First of all, for the first six months of the year the cumulative death rate among the many millions of people who are Industrial policyholders of the Metropolitan Life Insurance Company was only 2 per cent in excess of the record low point for the like part of 1938. Again, mortality data published by the Bureau of the Census for the general population of 88 major cities of the United States show that for the first 27 weeks of the current year deaths exceeded those in the corresponding period of 1938 by only 3.2 per cent — and 1938 was also the record year for low mortality for the country as a whole. Supplementing the figures from these sources are data for New York City, which show that the death rate for the general population of the City, up to July 15th, was only 2.9 per cent above that for the same period of last year — also the record health year in New York.

Furthermore, as the current year progresses, the outlook for a mortality rate very closely approaching the low point for last year becomes more and more promising. In support of this is the fact that while the death rate among the insured at the end of the first quarter was 3 per cent higher than that in 1938, the excess, by the end of the half-year, was only 2 per cent. An all-time record low for the month of June was an important factor in bringing down the cumulative rate for the first six months.

*Bull. Met. Life Ins. Co., July 1939*

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# The Treatment of Wounds\*

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I want to state at the beginning of this paper that nothing original is to be presented. The paper is merely my personal procedure adopted from teachings of many masters, from Paré on.

A wound may be defined as a solution of continuity of the tissues, and would therefore, include all subcutaneous injuries, such as bruises, fractures, etc; as well as lesions accompanied by rupture of the surfaces. Many injuries present mixed features.

It is obviously impossible to cover this subject in a fifteen minute discussion, so I will limit my remarks to the treatment of, fresh wounds, old wounds, and infected wounds.

Wounds should be considered emergency surgery. Unless there are definite contra-indications, wounds are right for active treatment up to four to six hours, possibly even up to eight hours. Our goal in treating wounds, is healing by first intention, and if they are not treated early our goal is not going to be attained. Surgical removal of the injured tissue, and immobilization after suture, have proved their worth. Factors such as the agent causing the injury, the place the injury occurred, the site, the size, type and depth, are all important factors. All these different factors as to what kind of injury exists and where it occurred, coupled with the time element allow us to divide wounds into:

- A. Uninfected wounds.
- B. Possibly infected wounds, or old wounds.
- C. Infected wounds.

There is a great deal of controversy on the preliminary, or pre-operative treatment of wounds. Because of the authority back of it, it would seem sensible to pack the wound with sterile gauze, then shave the skin widely around the wound, and scrub with soap and water, then rinse copiously with saline.

The wound proper is put through the same procedure before the debridement is done. After the debridement, or surgical excision of injured tissue, the same procedure is repeated. The

aim being to mechanically remove all foreign material, by soap and water, irrigation, the scalpel and forceps. The wound is thoroughly dried before suture.

The general treatment of the patient by intravenous fluids, or transfusion, may be indicated as a pre-operative precaution, as well as rest and heat. It is assumed that the surgeon will use all means at his command to put a shocked patient in the best possible condition before the operative procedure is begun.

Local anesthesia may be induced by the injection of  $\frac{1}{2}$  to 1 per cent novocain, in minor injuries but in any serious wound I prefer general anesthesia.

Two or three MM of skin are excised around the edge of the wound using a sharp scalpel. Then with a change of instruments the other layers are attacked removing every bit of damaged tissue. This excision is not carried out conservatively, but all lacerated muscular, tendinous, ligamentous tissue, as well as bone, nerves, and vessels that are injured are excised. Any undermining is widely opened up. Free exposure is the goal. Spurting vessels are clamped and the clamps left in place for a while to see if the bleeding can be stopped without ligatures. The less foreign material in the wound the better, but a bloodless wound is essential.

When the wound appears clean it is irrigated, dried and sutured by layers, using number 1 plain catgut for the muscle layer, chronic for the the facia, and clips for the skin. If the wound is of the arm or the leg a splint is applied, and the part elevated when the patient gets back to bed.

It will be noticed that I have made no mention of antiseptics. This is because I believe they are destructive to tissue, if effective as a germ killer, and I never use them except on the skin and seldom there. I believe the wide use of antiseptics is the result of professional inertia, and commercial propaganda. For those who

\*Read at the 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

insist on painting up wounds a 3% alcoholic solution of iodine is probably as good as anything.

If any cavity has probably been opened by a punctured wound the case should be hospitalized and the wound opened surgically and cleaned to its depth. Theoretically a punctured wound of any kind should get the same treatment. I always dislike these cases, for the majority seem to heal without infection, and the surgical treatment is more painful than the original injury.

Laceration bruises are frequent and accompany compound fractures. They especially call for debridement as a special precaution against gas gangrene. It is rare indeed for a properly treated wound to develop gas gangrene or tetanus. Ehalt, in *Weiner Klinische Wochenschrift*, 51:1213-1938, reports that he treated 25,000 cases of accidental wounds in this manner, that is by excision, and that 98% healed by first intention. Of 400 compound fractures 96.5% took a smooth course. Such results demand that more wounds be treated by this method.

Nerves are sutured primarily. If the wound is a smooth cut, tendons are sutured primarily, if it is a lacerated or old injury they are sutured at a second operation two months later. In case of skin defects the whole thickness skin graft gives the best result. There is not time in this discussion to elaborate on this point as it opens the whole field of Plastic Surgery.

Gas gangrene and tetanus are negligible if the wound is properly treated. So instead of using tetanus anti-toxin and anti-gas serum in every case, I reserve it now for grossly contaminated wounds, or wounds that are not treated by surgical excision.

This statement applies of course to the ordinary run of civilian injuries. In the next war we will see, beside proper surgical treatment a more general use of anti-gas gangrene sera, due to laboratory advancement. This will be a boon, for the French and German Surgeons have reported cases of gas gangrene in two hours, with death in five. This virulent type was especially noted during the Verdun offensive. Tetanus anti-toxin, of course is used on any doubtful case. I simply believe that it is used too routinely today.

I cannot let this opportunity go by, to say how rectal Avertin anesthesia has made it possible for us to keep our tetanus patients quiet while we

flood them with specific antibodies. Tetanus still kills, but not like it used to.

"Old wounds," by this term I mean wounds seen after the six or eight hour period. These are treated in precisely the same manner except that the deep sutures are placed and left untied. If there is no sign of infection in a day or two they are then tied. Carrel's technique of bacterial counting may help us to decide whether to tie or not. According to the surgeons judgment many of these cases will not be sutured at all, but will be left open. This is the group of cases to consider the use of Dakin's solution, using the Carrel technique. Since the World War this marvelous method has generally been forgotten. I put in a plea that surgeons generally reacquaint themselves with the procedure, and use it more often. I'll grant that it is tedious, but its well worth the trouble.

"Infected wounds." Active surgery is not indicated except for incision and drainage of a collection of pus. Following the classification of Kanavel and Koch, we will divide infected wounds in three groups.

1. Acute spreading infections. We mean that group of cases in which extensive injury has occurred and in which the presence and degree of bacterial contamination are still in doubt.

2. Localized superficial infections. This group includes the large group of cases which come under the term ulcer, and the infected wounds which follow burns.

3. Localized deep infections. This group includes abscesses and whether they follow a hair follicle infection, a ruptured appendix, or the invasion of the plural cavity with pyogenic organisms, the principles of treatment are the same.

For group 1. Our aim is to localize. We take our cue from the process of inflammation. This treatment may be summed up as consisting of bed rest and elevation of the affected part. This brings the assistance of gravity to the venous circulation, assists in the elimination of waste products, and in preventing congestion at the site of the injury. To carry our idea of physiological rest still farther, immobilization by splints helps immeasurably in some cases. As active treatment we advise the applications of warm moist dressings, kept moist every two hours, to the whole extremity, and that these



dressings be kept warm by the application of an electric baker over them. If the parts become edematous, the moist dressings should be stopped. Usually within three or four days the infection has cleared up, localization has occurred, or the infection has spread beyond control.

For group 2. With the localized superficial infection there is always suppuration with loss of tissue. Infection will continue as long as there is necrotic tissue present in the wound. Tissue which is obviously necrotic can safely be cut away, but this is a surgical procedure necessitating an anesthetic. Chemical debridement is safer than excision. Probably the most effective method is the proper use of Dakin's solution. This solution has a power of dissolving necrotic tissue without injuring live tissue. To obtain the best results it must be used in accordance with the technique of Carrel. The solution must contain .45% to .5% sodium hypochlorite. It must not be excessively alkaline, and it must be applied over the entire wound at two hour intervals. Sometimes these wounds seem to come to a stand still. Frequently cessation of any antiseptic or a change in the antiseptic will appear to speed healing.

As soon as the surface is surgically clean as evidenced by the absence of bacteria from smears of the wound, and the wound too large to heal itself, it should be covered with Thiersch grafts, or whole thickness skin grafts.

For group 3. When deep infection has localized, incision and drainage is in order. When properly done almost all cavities will fill in themselves, and in the more serious cases, healing can be speeded by using Dakin's solution following the Carrel technique.

Three other factors are of great importance, elementary procedures but widely ignored.

1. Changing the dressing often enough to keep the wound and skin edges free from wound secretion. So change at least twice a day.
2. Prevent reinfection by cleaning the skin.
3. Maintaining a constant and even pressure over the dressings that cover the wound.

It might not be amiss to advise the wearing of rubber gloves and the use of sterile instruments in doing dressings on infected cases. The gloves probably will not help the patient, but we know from many studies that germ contamination of the surgeons fingers is not easy to get rid of, and eight or ten minutes on the end of a sink brush does not make sterile fingers.

Among special methods of treating infected wounds, are blood transfusions from an immunized donor. This method has been disappointing in my experience. Specific antitoxin works well in diphtheric, tetanus, and gas infections, but in the common streptococcus and staphylococcus infections, this method has been disappointing.

In a few instances where the patient has been gravely ill and getting progressively worse with a staphylococcus infection, I have seen what looked like a miracle happen after the intravenous injection of 1% mercurochrome in doses of 10 to 20 cc. There have been recent articles in the literature that bear this idea out, and make it seem perfectly safe to use repeated doses of small amounts. Of course sulphanilamide must be mentioned, and in some streptococcus wound infections it works like magic. Its use as a prophylactic agent is being advised of late, but conclusions should be carefully drawn, because of the highly satisfactory results from surgical excision alone.



### A NEW PEAK FOR SMALLPOX

New Jersey, with a population of about 4,400,000, has not had a single case of smallpox in a period of more than seven years — since 1931. On the other hand, the States of North and South Dakota, Montana, Idaho, Oregon, Wyoming, and Utah, whose combined population is less than that of New Jersey, reported during the same period 12,666 cases of this loathsome disease.

As usual, the States chiefly responsible for the high small pox prevalence last year were those lying north of the Ohio and west of the Mississippi Rivers. These States, whose total population is only slightly more than half of the entire population of the United States, reported 14,166 cases of smallpox in 1938 as against only 945 cases for the rest of the country. As against this record, New England and the populous States of New York, Pennsylvania, New Jersey, Delaware, and Maryland, including the District of Columbia (total population 39,000,000) succeeded in utterly routing the disease from their borders; not a single case of smallpox was reported by these States during the entire year.

*Metropolitan Life Ins. Co.  
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## The Factor of Delay in the Recognition of Common Surgical Conditions\*

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In recent years, the factor of delay in the recognition of malignant tumors has been given considerable thought and investigation, because it has become increasingly apparent that a delayed diagnosis of cancer almost invariably adversely influences the prognosis of the disease.

Rafferty,<sup>1</sup> for example, analyzing the cancer records of the Windham Community Hospital, found that the average delay from the first symptom noticed by the patient, until hospital admission, was slightly over 1 year. Hirsche<sup>2</sup> found a delay of 1 year and 3 months for all cancer cases of the three New Haven Hospitals over a 10-year period, and reports from other sources prove equally appalling.

Similar analytical study, however, has not been accorded to the factor of delay in the recognition of common surgical conditions other than cancer. It is, perhaps, unnecessary to state that delay in the recognition of acute appendicitis, intestinal obstruction, ruptured viscus, and other acute intra-abdominal emergencies, may prove equally as disastrous as delayed recognition of cancer.

But there are many other conditions which, from a diagnostic standpoint alone, we might compare with cancer, because of their insidious onset and relative chronicity, and in which, delay in diagnosis, while not so devastating in its results as in cancer, may contribute greatly to the morbidity, and definitely influence the ultimate mortality.

Let us consider benign prostatic hypertrophy. A review of the last 50 consecutive cases admitted to our hospital, showed that the delay from the first symptom noticed by the patient, until hospital admission, averaged more than 4 years. Over 50% of these patients were not admitted until acute retention had developed. Almost all patients showed on admission low

renal function, abnormal blood chemistry, and other evidences of long standing obstruction at the bladder neck.

Whatever improvement has taken place in prostatic surgery in the past few years, and there has been improvement, has been due more to a better understanding of methods to relieve these complications pre-operatively, than to the opportunity of treating the disease earlier and before the complications had developed.

Let us consider also peptic ulcer, even though a relatively small percentage of cases ultimately prove to be surgical. Now peptic ulcer manifests a symptom complex which, as a rule, is so characteristic that it would seem to be readily suspected. Yet a review of the last 50 cases admitted to the hospital showed that the average elapsed time from the first symptom noticed by the patient, until hospital admission, was almost 4½ years, despite the fact that several cases in this series included acute perforations and acute bleeding ulcers, with no history of symptoms ante-dating the attacks.

But since ulcer is so often an ambulatory disease, a review was made of 87 consecutive peptic ulcers, proven radiologically, from my office records. It was found that the average time from the first symptom until office admission, was somewhat over 3 years, and the average for the entire group of 137 cases was approximately 3½ years. Only 2 of the 87 cases had x-ray examination prior to admission, and only 5 had been given the Sippy regime without x-ray examination.

While it might be contended that it would be difficult to evaluate the effect of delay in this series, the added morbidity which delay must entail, and the admitted importance of differentiating between gastric and duodenal ulcers, would make early and accurate diagnosis seem both advantageous and desirable.

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Let us consider, finally, gall bladder disease, which also, as a rule, shows a characteristic symptomatology. The last 100 consecutive cases of gall bladder disease admitted to the hospital were studied. It was found that the average elapsed time between the first symptom noticed by the patient, until hospital admission, was slightly under 4 years. Of these 100 cases, 3% were ruptured on admission, 10% had acute empyema of the gall bladder, and 29% were admitted in varying stages of an acute exacerbation of a chronic state. In other words, 42% of admitted cases showed one or more of the signs and symptoms of an acute inflammatory or obstructive lesion of the biliary tract, such as fever, jaundice, vomiting, pain, dehydration, etc. It is universally agreed that the mortality and morbidity of surgical procedures on patients in this category are definitely greater than in the quiescent group. Furthermore, it would be presumptuous to deny that neglected pathology of the gall bladder may lead eventually, to impaired liver, pancreatic, and even cardiac function.

Now what are the reasons for delayed recognition of disease states? It was impossible from our records to determine, in most cases, the reasons for delay, and I would like to suggest here that hospital records devote a line to the estimated delay, if any, and the reason for this delay, similar to our cancer records.

But at this point I refer again to the report of Rafferty<sup>1</sup> who found on analyzing our carefully obtained cancer histories, that the reasons for delay could be classified as follows:

Negligence on the part of the patient . . .	45%
Fear on the part of the patient . . . . .	9%
Ignorance on the part of the patient . . .	4%
Economic . . . . .	2%
Poor Medical Advice . . . . .	22%

These figures so closely parallel similar data from other clinics, that they may be accepted as a fair representation of the reasons for the delay in the recognition of cancer. It is my distinct

impression and opinion that these figures, if data were available, would also closely approximate the reasons for delay in conditions other than cancer.

If this be true, certain deductions might conceivably be drawn. It may be inferred that only a very small percentage of patients are deterred from proper advice and treatment by poverty. If negligence, fear, and ignorance on the part of the patient, account for about 58% of delay, and poor medical advice for 22%, it indicates that 80% of delay falls into a category which is remedial by education.

Several years ago the Philadelphia Academy of Medicine undertook an intensive educational campaign, both for the laity and the profession, to attempt to lower the incidence of ruptured appendices admitted to the Philadelphia hospitals. The result of this effort was a distinct decrease in the mortality of acute appendicitis in that area.

Certain insurance companies and drug manufacturers have recently indulged in national advertising, purporting to teach the layman the early signs of chronic disease, and the importance of seeking prompt and competent medical advice. Their work is commendable whatever the motives, but I feel strongly that we, as a State Society, may be considered derelict in our duty to the public if we do not, through the formation of appropriate committees, participate in this vitally important educational work. It is part of the newer concept of the sociological aspect of the practices of medicine, and we should not hesitate to recognize and develop it ourselves. We are already carrying on this work for cancer. It is the purpose of this paper to suggest that it may be desirable to include other clinical entities.

1. Rafferty, Brae: Analysis of the Delay in Cancer-Symposium Presented at the Tenth Meeting of Association of Connecticut Tumor Clinics — Connecticut State Journal, March 1939.

2. Hirsche, Herbert F.: The Cancer Problem in New Haven — 1935.

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# Discussion of Papers of Drs. McClure, Bissell and Ottenheimer

ARTHUR ALLEN, M.D.,  
Boston, Mass.

## I. Discussion of The Treatment of Burns, Dr. Roy D. McClure—

The first consideration is the importance of control of the various causes of severe burns by prevention, in which field are the identification and elimination of sources of injury in industrial processes.

In discussing treatment as the second phase of the burn problem Dr. Allen agreed that with the improvement of treatment that has been made, the remaining difficulties consist of:

1. The creation of widespread recognition of the necessity of the prompt and proper treatment of the lesion;
2. The maintenance of strict asepsis throughout the course of treatment;
3. The combating of secondary shock and toxemia without the creation of excessive chloremia and hemoglobinemia that the injudicious use of transfusion and saline infusion sometimes create;
4. The creation of the same attitude toward a burn area that one would assume toward a surgical field.

## II. Discussion of The Treatment of Wounds, Dr. A. H. Bissell—

In discussing this paper Dr. Allen extended the subject to a consideration of the preparation of the skin for surgical wounds, pointing out the advantages of preliminary washing and dressing and the excellent results obtained by Koch of Chicago from the use of soap and water alone. He also called attention to the use of ether and a 1% solution of iodine in alcohol and acetone in the preparation of the skin. Dr. Allen reemphasized the advantage of debridement of damaged areas over the application of the

various antiseptics and stressed the desirability of copious irrigation of the injury. He also mentioned the newer concept of chemotherapy of a local area through the body rather than by local treatment alone, pointing out that the Dakin treatment is of little use unless carried out in the most meticulous and painstaking manner. He deplored the routine use of sulfanilamide for prophylaxis and advanced the idea that if a localized streptococcal (hemolytic) infection could be treated without specific chemotherapy (sulfanilamide) the patient could thereby derive the benefit of naturally acquired immunity against subsequent infections.

## III. Discussion of The Factor of Delay in the Recognition of Common Surgical Conditions, Dr. E. Ottenheimer—

Dr. Allen reemphasized all of the salient points of Dr. Ottenheimer's presentation and confirmed the percentages that the different causes of delay by the patients in seeking surgical treatment represented. He also commented upon the high number of cases of gall bladder and biliary system disease which receive only medical or expectant treatment and which do not come to the surgeon's attention until the patient is aged or otherwise a poor surgical risk, and added that most cases of ulcerative colitis are in such poor condition that they are bad risks for ileostomy.

He gave especial attention to the handling of peptic ulcer, especially when located in the stomach. He stated that extensive healing, as demonstrated by roentgenography, does not exclude the possibility of carcinoma and that the case should be followed by x-ray more frequently than the customary three to six months. The type of treatment, medical or surgical, should be determined by the ability of the patient to follow an ideal ulcer regime.



## The Problem of Cleft Lip and Cleft Palate\*

CLAUDE C. KELLY, M.D.,  
Hartford, Conn.

I can think of few subjects in surgery, the presentation of which would be more boring to the average physician than the details of the technical difficulties encountered in the repair of cleft lip and cleft palate deformities. The operations for these conditions will not be given in this paper.

Cleft lip was described by Galen, who devised an operation for its repair. The name "Hare Lip" was given to the condition by Paré in the sixteenth century and it was not until 1776 that LeMonnier successfully closed a cleft palate.

Cleft lips may present only a small notch in the margin of the lip, involving only a part or all the vermilion border, with or without a line resembling a post-operative scar which extends from this notch into the nostril. There may be any gradation from this to the complete cleft, which includes the entire length of the lip on one side, or there may be involvement of both sides, which may be partial or complete, with a protrusion in the midline resembling a snout. There is an occasional cleft of the midline.

The cleft palate may include only the alveolar margin, or it may include any portion of the hard palate or the soft palate, or any combination of the two. The cleft may be single or double, partial or complete.

You may have a cleft lip without a cleft palate, or a cleft palate without a cleft lip. Three fourths of the cleft palate cases have associated cleft lips.

Cleft lips and palates are said to be slightly more prevalent in the male than in the female. Clefts of the lips occur four times as often on the left side as they do on the right side. It is interesting to note that forty-six per cent of the clefts occur in the first born and it seldom occurs after the fifth child.

Clefts of the lip and palate are a great deal more prevalent in some countries than others

and also in different sections of the same country. They are very common in China, India and Finland. The world war recruits in this country showed a ratio of 1.55 per thousand in Vermont, while there were .16 per thousand in Arkansas. These deformities do not occur as often in the negro race as they do in the white race. Statistics vary with different localities and the incidence of cleft lip and palate ranges from one cleft in 1200 births to one cleft in 2000 births.

What is the cause of cleft lip and cleft palate? That question is asked by nearly every parent who has one of these children. There are many theories and some will be mentioned in this paper.

Certain observers have thought that amniotic or chorionic adhesive bands are responsible. Brophy believed that the relatively large tongue in the embryo caused enough pressure against the palate to prevent fusion. It has been said that the pressure of the lower jaw against the upper, by the extremely flexed head of the embryo, is a factor. Syphilis and alcohol are mentioned as causes. I think the more plausible theory is that the germ plasma is at fault and prevents the fusion of the embryonic processes at the proper time. Heredity is the most important factor and it is stated that a familial history of these deformities is present in from twenty to fifty per cent of the cases.

A most interesting experiment has been carried out by Fred Hale of the A. & M. College of Texas. He produced pigs with hare lip and cleft palate deformities, together with many other defects, by feeding the mothers a diet withholding all Vitamin A content for 160 to 190 days before the pigs were born.

The optimum time for operations on the lips is from two weeks to two months, depending on the physical condition of the child and the se-

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verity of the cleft. No lip or palate operation is considered an emergency in our hands.

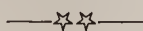
We operate on the palate when the patient is from one to two years of age, depending on his general condition. We think it is well to have the palate closed before the child learns to talk. We operate on older children and adults if their operations were not completed in infancy.

The pediatrician is of inestimable value in preparing these children for operation. We consider red blood count, hemoglobin and bleeding time to be very important. We can usually feed the children with a medicine dropper, spoon or syringe, to which a catheter is attached. We feed the small baby to within three hours of operation, and begin feeding as soon as tolerated after operation. We give feedings from sterile receptacles for two or three days postoperatively. The child wears cuffs to prevent interference with suture line and is restrained when necessary. We give sufficient paregoric or morphin for sedation. The cleft palate cases are given liquid diet until the sutures are removed.

It is sometimes necessary to do several operations on some of these cases and we think the parents should be told this before the first operation is done.

Every cleft palate case with involvement of the alveolar margin and irregularity of the teeth should be under the care of an orthodontist. In some complicated cases dental appliances are of inestimable value in improving speech. We believe that speech training is very valuable and that the mother is the best teacher, but when possible she should be aided and advised by a trained instructor.

If, after hearing this paper and seeing the pictures of the operative cases, you have obtained any information which will enable you to give hope and courage to the almost disconsolate mother of a deformed child, I will feel that my efforts have been worth while.



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## Urogenital Deformities\*

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Anomalies of the genito-urinary tract are probably more frequent than of any of the other systems or organs of the body. Almost all of these conditions whether they are discovered at birth or in adult life require some degree of medical or surgical treatment and as a rule early treatment proves both easy and beneficial to the patient.

Phimosis is very common and varies from a complete constriction to only slight difficulty in retraction of the foreskin. Many patients have avoided a circumcision in childhood only to find themselves tortured in old age by an infection under a tight prepuce. Operation at this time often proves more painful and frequently as serious as a major procedure. I can think of no operation which gives a patient more comfort, with so little need for worry of a recurrence, than a neatly done circumcision before the age of seven. The occasional case of very troublesome adhesions between the glans and the mucosa of the prepuce after operation should always be kept in mind as well as the danger of excising too much of the foreskin.

Undescended testes are very common and have received the most attention in recent years. This condition is easily recognized. The type of abnormality, however, is very important from the standpoint of treatment. First, we recognize that group of cases where no mechanical factors of obstruction are present. Only these cases are amenable to hormone treatment. Both the male sex hormone and the gonadotropic hormone of the anterior lobe of the pituitary are effective.

One may expect to obtain results in about fifty per cent of these cases after the use of an average of four thousand rat units of the hormone. Treatment is usually started after the age of seven and is best given before puberty. Flushing of the genitalia and enlargement of the testes

and penis are common symptoms following this treatment.

If a test of the prospective patient's urine shows the presence of the hormone the outlook is more favorable. One should not use hormone treatment on the following four groups of cases.

- (1) Where a hernia or hydrocele is involved.
- (2) Where mechanical obstacles are present.
- (3) Migrating testes.
- (4) Aberrant position of the testis.

The testes may be found in aberrant positions such as the femoral region, above the symphysis or even in the perineum. The testis may have descended only partially due to a short spermatic cord or its accompanying vessels. In these conditions it is obvious that the hormone treatment is useless.

Cases of undescended testes that have not responded to treatment should be considered as a surgical problem and it is well to keep in mind that the undescended testis is apt to be sterile and at times becomes malignant.

There are frequent anomalies of the male urethra, such as congenital strictures, occurring at the external meatus and often in the posterior urethra. Frequently all that is necessary is to dilate these. Congenital dilatation, diverticula and so called "valves" are occasionally encountered.

Epispadias, an incomplete closure of the dorsal surface of the urethra, is rare but often occurs with extrophy of the bladder. Hypospadias, an incomplete closure of the ventral surface of the urethra, is much more common and occurs in varying degrees. The external opening of the urethra may be found just back of the glans, midway under the penis or at the penile-scrotal junction. Frequently there is a stricture of the external opening in this anomaly. This stricture often requires dilating even at birth but any plastic operation on the urethra is best done

\*Read at 147th Annual Meeting Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

after the age of seven. Double urethra and penis may occur. These are important chiefly because of the loss of function which results.

Extrophy is by far the most important anomaly of the urinary tract. It is at the same time the most difficult to treat and the most distressing to the patient. Fortunately it is rare and occurs once in about thirty-five thousand cases. About eighty per cent of these are males.

This condition is easily diagnosed, at birth there appears a fleshy mass above the pubis which is covered with mucous membrane and oozing urine. Close examination will reveal urine spurting from the ureteral openings at intervals.

Transplantation of the ureters into the sigmoid and rectum with excision of the bladder is the accepted treatment at the present time. The more conservative procedure of transplanting the ureters to the skin in the flank is seldom done at present and leaves the patient draining urine constantly which is very distressing to him as well as his friends.

A patent urachus is a fairly common finding and may be open at either end or be complete and urine may be found to exude from the umbilicus. Ligation or excision readily cures this condition.

Since the introduction of intravenous urography and perhaps due to the more careful study of patients, anomalies of the kidneys and ureters have been found in increasing numbers especially in children.

Duplication of the ureters or pelves or both are quite common. This anomaly is very apt to be inherited and in our own series of cases we have a family of four girls all of whom have double ureters. These as a rule require little or no treatment but the knowledge of their presence is valuable. Kinking of the ureters occurs at times and it is not unusual to remove one of a double pelvis with good results.

Ectopic kidneys are frequent and may be located in any position from the bladder to the normal position of the kidney. One is often able to distinguish between an ectopic kidney and a ptosis by the fact that the ectopic kidney has a short ureter and the ptosed kidney has a redundant one. The pelvis of the ectopic kidney is often deformed and frequently suggests a kidney tumor.

An ectopic pelvic kidney is often first discovered at operation where it has been mistaken for a mass involving the pelvic organs. The surgeon at this time invariably leaves the kidney because he lacks information about a normal kidney on the other side. It has been estimated that a solitary pelvic kidney exists once in twenty-two thousand persons.

The opening of the ureter is often found in unusual places. In the female it is found to open into the vagina, thus causing incontinence. It may open into the urethra or into the bladder at some distance from its usual site.

Many other anomalies are found but time will only permit the discussion of these most important ones.



#### SULFANILAMIDE FOUND TO HAVE TENDENCY TO SLOW NORMAL HEALING OF WOUNDS

Sulfanilamide tends to slow the normal healing of wounds, and its use to prevent infection following operation may therefore prove to be unwise, it is indicated by experiments reported in *The Journal of the American Medical Association* for June 24.

The experimenters Eugene M. Bricker, M.D., and Evarts A. Graham, M.D., St. Louis, performed their studies on dogs, giving the drug to some and withholding it from others. For about five days the wounds of dogs given the drug healed less slowly and were less strong than those dogs not receiving treatment.

By the seventh day after operation the wounds of both treated and untreated dogs were almost equal in healing and strength.

Explaining the reasons for the experiments, the physicians state, "The enthusiasm with which sulfanilamide is being used in the treatment of infections of all kinds has tended to minimize a consideration of the possibility of any harmful effects of the drug. Recently the idea has been expressed by many that it might be used prophylactically before certain operations in which the chance of wound infection may be great. It seemed desirable therefore to determine whether or not this drug has any inhibitory effect on wound healing, especially since antiseptics as a group do have such an effect."



## Congenital Orthopedic Deformities\*

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Congenital deformities of the bones, joints and muscles comprise a rather large and varied group of deformities, differing considerably in the degree to which they disable the patient and in their amenability to treatment. There are two ideas however, which have been all too prevalent among the general medical profession, concerning these cases. First, that nothing can be done for these unfortunates, and second, that as time progresses they will grow out of them. In general these deformities may be of two types; primary or idiopathic, due to inherent defects in the fertilized ovum, and secondary deformities in which in the beginning the fetus is normally formed but through some external cause, deformity arises.

Among a rather large group of miscellaneous congenital deformities there are several in particular which warrant more especial consideration particularly with regard to their early recognition and early treatment. In some of these the deformity is obvious at birth and requires no special powers of observation or care in examination for their detection. An infant born with one or both feet markedly deformed and inverted has a congenital deformity obvious to the most inexperienced eye. Another with a congenitally dislocated hip or a torticollis may remain unrecognized for many months unless carefully and meticulously examined.

The problem thus revolves itself, first into early diagnosis and secondly into early treatment in order to secure the best results. With regard to the first, the responsibility lies squarely on the shoulders of the family doctor or pediatrician. It is he who has the opportunity to see the new born infant and watch its growth and development in the early months of infancy. He should note any abnormality in development, any variation from the normal particularly in the use of the extremities. He should view with

suspicion any unusual attitudes in which the head or extremities are held and undertake to ascertain whether or not any underlying pathological condition may be responsible. No longer should he pass the matter over with a reassuring smile and tell the anxious parent that the abnormality noted is just a habit which the child will outgrow in time. Our orthopedic clinics are all too full of children finally brought for treatment years after the abnormality was suspected but in whom treatment was neglected because the parents had been told that it was of no consequence or would disappear with time and growth. An ever watchful attitude on the part of the family doctor, the obstetrician and the pediatrician will do much to detect these cases early when the most satisfactory treatment can be rendered, and the best result secured.

Another erroneous attitude on the part of the attending physician which I believe is becoming less frequent but nevertheless occasionally is still encountered is that "nothing can be done," or that the child is too young for treatment. One cannot deny the fact that for some conditions little or nothing can be done, but orthopedic and reconstructive surgery is advancing from year to year and conditions which at one time were not considered amenable to treatment may now in some instances be greatly improved. As for the child being too young for treatment, that after all should be a matter for the surgeon to decide. Treatment which a few years ago was postponed is now often carried out at an earlier age than previously attempted in an effort to secure prompt and more satisfactory results. The elimination of these two faulty attitudes towards these congenital deformities on the part of the medical profession, on the one hand unjustified optimism that nature will effect a spontaneous cure in time, and on the other the attitude of hopelessness, that nothing can be done, should

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do much towards the prevention of crippling and suffering in many of these cases. Early recognition of something wrong on the part of the family practitioner with the matter of final diagnosis, character and time of treatment left to the consultant orthopedist should be our aim.

Let us consider briefly several of the commoner congenital deformities in the light of early diagnosis and treatment. The first of these is congenital torticollis or wry neck.

It would appear likely that there are two forms of congenital torticollis, a rarer type in which the deformity is already present at birth, and the more common type that develops a few weeks following birth as a result of trauma to the sternomastoid muscle and secondary cicatrization and contracture. In both of these the resulting deformity is the same, the head deviating towards the contracted muscle and the chin to opposite side. It must be emphasized that this deformity requires treatment, preferably early treatment, and that the child does not spontaneously grow out of it. Every new born infant should be examined to determine the presence or absence of a sternomastoid hematoma. Simple daily treatment at this time will in most cases bring about a complete cure and prevent the necessity of late operative measures. The head should be regularly manipulated against the contracture of the sternomastoid, starting treatment as soon as possible after birth. The hematoma if present should be massaged. In bed, no pillow should be used, and the infant placed on the side to which the occiput rotates. By these simple measures, full correction in a larger percentage can be secured in a few weeks.

If treatment is neglected or postponed, the deformity becomes more and more fixed. The other soft parts of the neck become adaptively shortened and in long continued torticollis there develops a secondary scoliosis of the dorsal spine, and a more or less marked asymmetry of the face. The vertical length of the face is shortened on the side of the affected muscle and the eye is lower on that side. This facial asymmetry which is very marked in some cases is less conspicuous in the deformed position than when the head is straightened. Fortunately however, unless the deformity is too advanced this asymmetry tends to gradually disappear after correction. Ocular disturbances resulting from

chronic eyestrain have also been reported as a result of long continued deformity. Late treatment is necessarily operative and time consuming. The secondary deformities of scoliosis and facial asymmetry at times cannot be completely corrected, and there is necessarily a scar which in a girl is undesirable. All these disturbances can be prevented if the condition is only recognized early and adequate treatment is commenced shortly after birth.

Another congenital deformity in which early recognition and early treatment are essential in order to ensure a complete correction with the expenditure of a minimum of time and effort is that of congenital clubfoot. Although congenital talipes or clubfoot may be of various types, for the purpose of this discussion the term will be considered synonymous with the equinovarus type of deformity. In this deformity there are three distinct elements, adduction of the forefoot, varus or inversion of the foot as a whole, and equinus or shortening of the heel cord and posterior capsule of the ankle joint. Any one of these elements in the resultant deformity may predominate so that it is obvious that all cases of talipes equinovarus are not necessarily identical. Again, the degree of distortion varies considerably, ranging from an extreme deformity to a mild turning in of the foot which simulates the normal attitude in which many infants carry their feet. Here again it is important that the attending physician be able to recognize the abnormal from the normal so that treatment may be instituted early. Careful examination elicits the fact that the child with a normal foot held in slight varus can easily overcorrect the deformity, if proper stimulation is given; the child with a mild clubfoot constantly maintains the position of varus and is unable to overcorrect the deformity by himself regardless of stimulation.

The cure of congenital clubfoot has always presented a difficult problem. In spite of many recognized methods of treatment, unsatisfactory results are still common.

The three principal causes of failure are delay in inauguration of treatment, imperfect nerve supply to the muscles, and failure to obtain complete overcorrection of the deformity. Probably one of the most common of these is delay in starting treatment. It used to be felt that no effective treatment could be carried out in



these cases of congenital clubfoot until the infant was three or four months of age. By this time, however, the soft part contractures have become fixed, the heel cord has become more rigidly shortened and the problem has become increasingly complicated. Later it was felt that treatment could be commenced at the age of two to three weeks. But here too, valuable time has been lost and the deformity allowed to become more or less fixed. Treatment can and should be commenced within a day or two of birth, if the infant is otherwise healthy. The clubfoot is manually manipulated into the position of as much correction as can be secured without embarrassing the circulation. Here it is fixed with a few strips of adhesive applied to the dorsum of the foot, passing down the inner side, under the sole and up the outer side of the calf where they are fixed to the skin. By careful manipulation and application of these adhesive strips, most of the varus deformity can be corrected at the first sitting. Every 2-3 days the adhesive is removed and further correction secured until full over-correction of the varus has been obtained. Then the foot is forced up into dorsiflexion and the heel cord is gradually lengthened while the foot is kept abducted in full valgus. Contrary to previous belief, the skin of the new born infant tolerates the application of adhesive, if carefully applied, without difficulty. Needless to say, excessive constriction must be avoided in order to avoid blisters and circulatory impairment. By this regime within a week or two, full over-correction of the deformity can be secured. With care, even in the smallest feet, a retentive plaster cast can now be applied extending from the toes to the mid thigh with the knee flexed. This will only be changed every 3-4 weeks according to the rate of growth of the infant. In a relatively short time all immobilization can be removed and a cure effected, all without forcible manipulations, anesthesia or any operative measures. Contrast this result from early treatment to the forcible wrenchings, fasciotomys, tenotomies and even wedge tarsectomies so often necessary in the neglected cases. In the first we get a normal appearing, flexible, painless foot; in the latter, only too often a stiff rigid, awkward member prone to relapse with recurrence of the original deformity is apt to result. Early, careful, painstaking treatment of this deformity gives the best and most lasting result in the shortest time.

Congenital dislocation of the hip is the most important congenital deformity in many ways with which we have to deal. In the first place it is probably one of the commonest. According to some statistics it occurs four times as often as clubfoot and twelve times as often as torticollis. In the United States the incidence is probably not nearly so high, but nevertheless it is undoubtedly a fairly common condition.

In the second place congenital dislocation of the hip is of especial importance in that the deformity is not obvious at birth. As a result, in the vast majority of cases it is not recognized until the age of  $1\frac{1}{2}$  to even 2 or 3 years when the child begins to walk and a slight limp becomes apparent. Even then the treatment of many cases is neglected and only too often the family doctor is at fault, either making light of the awkwardness of gait or telling the anxious parents that in time the child will grow out of it and the limp will disappear spontaneously. Unfortunately, the reverse is the case; the limp becomes progressively worse, the deformity more and more apparent, and the chances of securing a cure steadily less as time goes on.

The reason for this increasingly serious prognosis is simple enough. As soon as weight bearing commences, serious secondary developmental changes occur in the socket and the femoral head and neck which make reduction more difficult and retention more insecure. Beginning as a slight subluxation at birth, the dislocation could in most cases be replaced with ease and certainty if the diagnosis were only made at that time. But continued function and particularly weight bearing on the unreduced hip results in serious adaptive changes.

The acetabulum tends to become shallower due to filling up with soft tissues, particularly the redundant and adherent capsule. As weight is borne on the unsupported femoral head, lying as it does on the outer aspect of the ilium, it tends to be tilted anteriorly so that gradually a more or less marked degree of antiversion or torsion of the neck of the femur is likely to develop. In addition, due to irregularities of pressure and strain on the femoral head incident to weight bearing, its articular cartilage becomes indented and flattened and the whole shape of the head grossly distorted and misshapen. Finally, due to the fact that it must necessarily support most of the weight of the body in walk-

ing the capsule of the hip joint gradually becomes elongated and markedly thickened and adherent to the adjacent ilium and acetabulum.

As a result of these changes in the acetabulum, femoral head and neck and capsule, reduction after weight bearing has commenced becomes increasingly difficult and the problem of retention if reduction can be secured, increasingly problematical. Obviously then the earlier the diagnosis, the less prominent are these secondary adaptive changes, and consequently the easier the reduction and the more favorable the prospects of securing a normal hip.

Early diagnosis then is the first essential in treatment. Up to the present very few cases are diagnosed in infancy before the child attempts to walk. There are however, a number of symptoms and signs which should be looked for in routinely examining every infant which are very suggestive of a dislocation.

1. Habitual outward rotation of one leg.
2. Shortening of the affected leg.
3. Fullness over the trochanter causing an apparent widening of the pelvis on that side.
4. Abnormal mobility of the hip especially in rotation, and often some limitation of full abduction.
5. A difference in the inguinal and gluteal folds on the two sides.
6. A sense of crackling or click in the hip which is felt when the leg is moved.

If any of these signs are noted by the attending physician an x-ray should be insisted on and frequently the suspected diagnosis can be confirmed.

Once the diagnosis is made in such an infant what then? It used to be felt that treatment had to be postponed until the child was past the bedwetting age so that the retentive plaster casts that were applied would not become soiled or broken. During the past few years however, more of these infantile cases have been brought to the attention of the orthopedist, and other methods of treatment have been devised to supplant the cumbersome plaster casts. The fundamental principal in this treatment is gradual abduction of the hips to the maximum, constantly maintained in a brace with a pad exerting constant pressure downward and inward on the trochanter so as to steadily force the femoral head toward and finally into the acetabulum.

By this means reduction can be secured and maintained and a normal hip often secured before weight bearing is commenced.

In conclusion — there must be emphasized the need for constant vigilance on the part of the family doctor in order to make an early diagnosis, and the need for a closer cooperation with the consultant orthopedic surgeon in order that early treatment may be commenced. If this can be carried out much will have been accomplished.

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### WHAT IS OSTEOPATHY?

"Is it medicine or is it not? Do schools of osteopathy teach medicine or do they not?" asks an editorial in *The Journal of the American Medical Association* for April 29.

"Last year 144 applicants whose training had been received in osteopathic schools were licensed by the boards of medical examiners in ten states to practice medicine, surgery or both; 101 were licensed after examination and forty-three without examination.

"In a number of states bills have been introduced which, if passed, would give to graduates of osteopathic schools the same privileges and responsibilities that are given to graduates of approved medical schools. Is such legislation compatible with public safety or in the interest of public welfare? Proponents of these measures claim that medicine is taught as completely and as thoroughly in schools of osteopathy as in schools of medicine.

"Osteopathic schools have consistently refused to permit an inspection by the Council on Medical Education and Hospitals of the American Medical Association. Recently, however, a committee of the Kansas legislature visited one of these schools and found conditions which a recognized medical school would not tolerate. In the medical sciences, anatomy, biochemistry, physiology, bacteriology and pathology the faculty was utterly inadequate both in numbers and in scientific training. For teaching the various clinical branches of medicine the number of hospital patients available was about one twenty-fifth of the number to which students at the University of Kansas have access. This school of osteopathy, at least, does not even remotely approach the generally accepted standards of education for the practice of medicine."



# Management of Congenital Defects of the Nervous System\*

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Congenital defects of the nervous system may result from defective germ plasm or from intra-uterine damage. Those anomalies due to defective germ plasm are frequently hereditary and are usually transmitted as a recessive characteristic. The various cerebral aplasias are only of importance from the standpoint of prognosis. Porencephaly is the chief exception to this generalization because of the frequency of convulsive symptoms and the possibility of their relief by appropriate surgical therapy. Cranial malformations, especially those described as oxycephaly, occasionally justify surgical efforts to increase the size of the cranial cavity. The more common congenital anomalies in which surgical treatment is feasible are those related to defective closure of the cerebrospinal coverings (cranium bifidum and spina bifida) and to the cerebrospinal fluid (hydrocephalus).

## Cranium Bifidum

Cranium bifidum or cephalocele is a defect in closure of the cerebral or cerebellar coverings and is usually located in the mid-line, most frequently in the occipital or suboccipital region. Occasionally the defect occurs at the anterior pole of the cranial axis and may present between the eyes or into the nose. The protrusion of meninges through such a cranial defect (meningocele) produces a visible mass which reflects the changes in intracranial pressure consequent to cardio-respiratory movements and posture. Portions of the nervous system may likewise protrude through the defect (encephalocele), contributing materially to the surgical problem involved. When the cutaneous covering is absent over such a cranial defect the probability of meningeal infection is imminent and immediate closure of the defect should be attempted. It is probable that the sac of a meningocele may contribute considerably to the absorption of cere-

brospinal fluid. For this reason it is advisable to retain as much as possible of the sac when an open fluid communication exists through the cranial defect. The sac may be effectively covered by fascia and scalp in most instances. Meningoceles presenting into the nose require an intracranial approach for closure of the defect and should not be excised as nasal polyps. When adequate cutaneous covering is present over a cranial defect it is usually advisable to wait until the age of three or four years before attempting surgical repair.

## Spina Bifida

Defects in closure of the spinal coverings (spina bifida) comprise the most common congenital anomaly of the nervous system, requiring surgical treatment. The incidence of spina bifida, exclusive of the occult type, is about one in one thousand births. The defect is most frequently located in the lumbosacral region, and is probably a recessive hereditary characteristic. The frequent lumbosacral location of the anomaly is explained by the fact that the lower portion of the neural canal is the last part to close during fetal development. The frequent association of hydrocephalus with these defective closures of the spinal canal suggests that the causative factor may be a defect in the absorptive mechanism for cerebrospinal fluid, producing increased pressure in the cerebrospinal system during the period of closure of the neural tube. Protrusion of a meningeal sac through a spina bifida constitutes a meningocele (Fig. 1B). The meninges are usually covered by skin and the hazard of meningeal infection is relatively slight in this type. More common is the inclusion of portions of the spinal cord or spinal roots in the meningeal sac, producing a myelomeningocele (Fig. 1C). The cutaneous covering of the sac is usually defective in this variety

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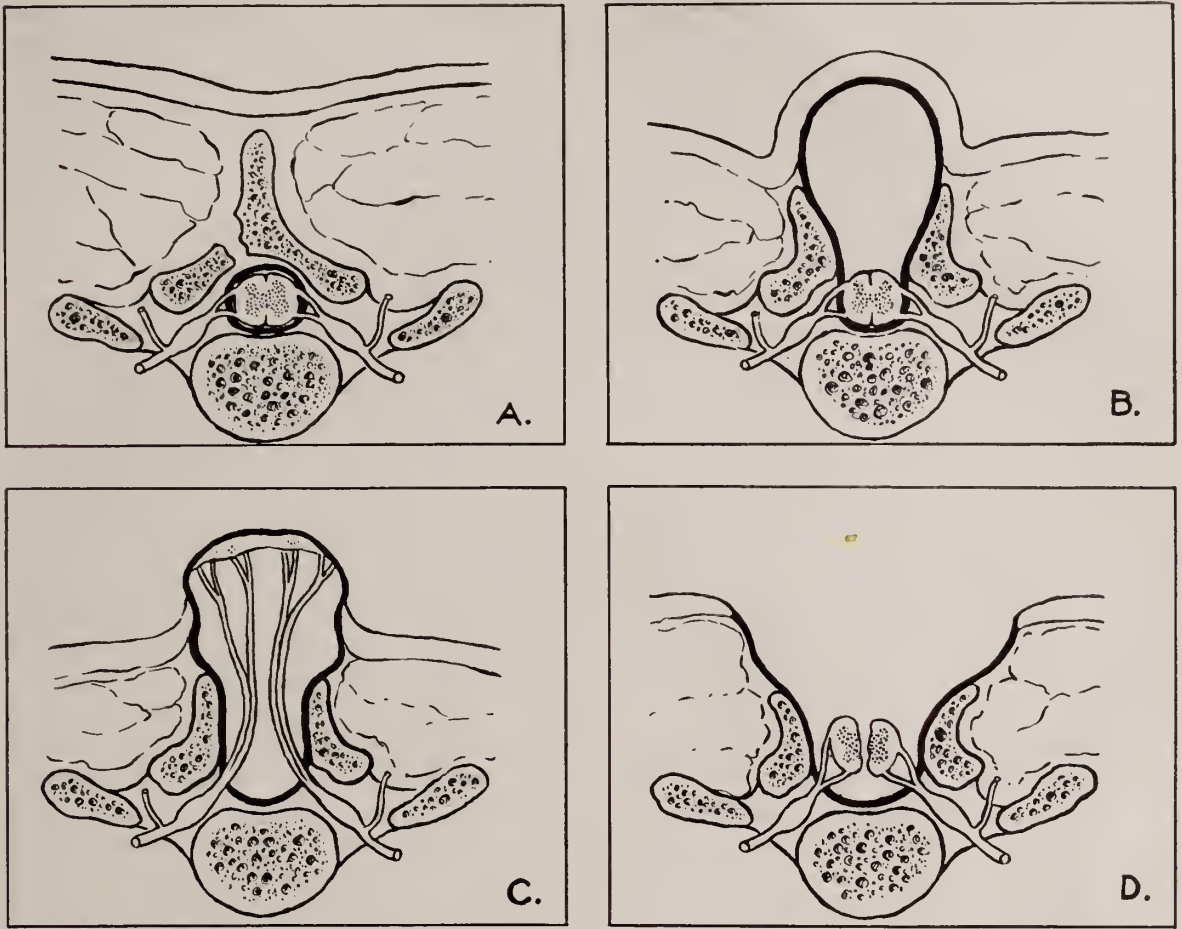


FIGURE 1

and the prevention of infection constitutes the primary surgical problem. Paralysis are usually present in cases of myelomeningocele and the incidence of hydrocephalus, either before or after surgical repair, is considerably greater than in cases of simple meningocele. Rachischisis is an extensive defect in closure of the spinal canal and even the meningeal covering is usually deficient in these cases. (Fig. 1D.) The spinal cord is usually anomalous, often consisting of two portions, and extensive paralysis are present.

Spina bifida occulta is a simple defect of closure of the spinal canal without protrusion of meninges. (Fig. 1A) It occurs most frequently in the lower lumbar or sacral region and the diagnosis is made by x-ray examination. Although symptoms are usually lacking, occasional cases of spina bifida occulta may develop neurological disturbances, especially vesicle incontinence,

during the second decade of life. In these cases there may be a small myelomeningocele attached to the bony defect which exerts progressive traction upon the roots of the cauda equina as growth of the spine occurs. The spine grows more rapidly than the cord so that a progressive relative discrepancy in cord length compared to length of the spine normally occurs. This explains the late appearance of symptoms in spina bifida occulta. Surgical therapy may be effective in relieving symptoms by freeing adhesions to the cauda equina at the site of the spina bifida.

The therapeutic indications in the various kinds of spina bifida are primarily dependent upon the type of covering of the spinal defect. In cases of simple meningocele where the sac is covered by skin, surgical treatment may be postponed until the age of three or four with



relative safety. In cases of myelomeningocele, where the skin is defective over the meningeal sac, the problem of infection immediately assumes paramount importance. The involved area should be kept sterile from the time of birth and surgical closure of the defect should be done in most instances during the first day of life. Possible contraindications to operation are pronounced hydrocephalus at the time of birth or very extensive paralysis. The latter is perhaps a matter of social rather than surgical significance and the attitude of the family in this matter is worthy of consideration. In cases of extensive rachischisis it is questionable whether attempts at surgical repair are indicated.

Until the present decade the results of surgical treatment of meningoceles and myelomeningoceles had been most discouraging. The situation is well illustrated by the report of George D. Cutler (1) in 1924, who reviewed a series of fifty-seven cases of spina bifida from the Children's Hospital, Boston. Thirty-nine of these children were operated upon with a mortality of 43%. There were twenty-four myelomeningoceles and fifteen meningoceles in this series. Thirty-eight per cent of the cases operated upon developed some degree of hydrocephalus after operation. Since excision of the sac was done in all these cases the question immediately arises concerning the possible causal relationship between sac excision and subsequent hydrocephalus. However, a second group of eighteen cases which were not operated upon were included in Cutler's report and the incidence of hydrocephalus in this group was essentially the same, 39%. In 1932 Penfield and Cohn<sup>2</sup> reported a series of about twenty cases, eight of which were myelomeningoceles. The mortality in this series was 6%. They emphasized the importance of preserving the sac and stated that no hydrocephalus developed in any of their cases but that definite enlargement of the head occurred in several patients. The incidence of hydrocephalus following operation is thus subject to considerable variation in interpretation. In 1933 Kolodny<sup>3</sup> reported a series of seventy-six cases, thirty-one of which were myelomeningoceles or rachischisis, while forty-two were simple meningoceles. Sixty of these patients were operated upon with a total mortality of 5% and a mortality of 14.2% in the myelomeningocele group. Only the base of the meningeal sac was saved in Kolodny's cases.

It is obvious that the operative mortality and the incidence of hydrocephalus should be somewhat proportional to the percentage of myelomeningoceles and rachischisis in the series, and inversely proportional to the percentage of simple meningoceles. For the purpose of obtaining more information on these factors, twenty consecutive operative cases from the New Haven Hospital have been analyzed. (Table 1.) Only two cases were simple meningoceles while eighteen were in the group of myelomeningocele and rachischisis. There were two operative deaths, a mortality of 10% for the entire series or 11% for the group of more extensive defects (myelomeningocele and rachischisis). One death occurred in a child with multiple congenital defects, including a large umbilical hernia containing the major portion of the intestinal tract. Fourteen of the cases have been adequately followed since operation (all myelomeningoceles or rachischisis). Of these, one died at the age of four months and a second at the age of thirteen months, the latter from broncho-pneumonia. Hydrocephalus was present before operation in six cases and appeared after operation in five cases. The hydrocephalus was sufficiently pronounced to require surgical treatment in five cases. In two of these the surgical attack on the hydrocephalus was done before repairing the spinal defect. Although the meningocele sac was preserved in all but two

**TABLE 1**  
**Results of Surgical Treatment of**  
**Spina Bifida**

I. Meningocele—2	II. Myelomeningocele including rachischisis —18
Total Cases	20
Operative Deaths	2
Mortality	10% or 11% for Group II
Cases followed:	14 (all myelomeningoceles)
Hydrocephalus before operation	6
Hydrocephalus after operation	5
	(not present before)
Hydrocephalus requiring treatment	5
Before repair of myelomeningocele	2
After repair of myelomeningocele	3
Deaths after leaving hospital	2
1 at 4 months	
1 at 13 months (bronchopneumonia)	

cases, the incidence of some degree of hydrocephalus in the sixteen surviving cases of myelomeningocele and rachischisis was 31%. The presence of myelomeningocele and congenital hydrocephalus in brother and sister was encountered in one instance. (Figure 2.) In the male infant hydrocephalus progressed rapidly after repair of the myelomeningocele and excision of the sac. Because of this unfortunate experience no attempt was made to repair the myelomeningocele in the female infant. In spite of this, rapid progression of the hydrocephalus occurred with an ultimate fatality. From the results of this series it is obvious that hydrocephalus is frequently present even before repair of the spinal defect, and that progressive hydrocephalus may occur after such a repair even though the meningeal sac is preserved. Finally, the operative mortality even for the more extensive group is within reasonable limits.

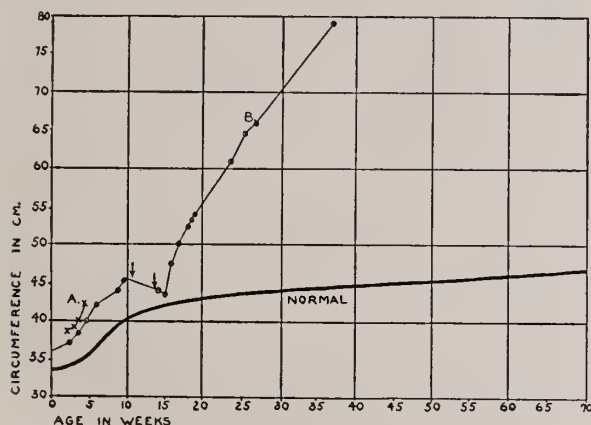


FIGURE II.

### Hydrocephalus

Hydrocephalus may be of three types: 1. productive, 2. obstructive, 3. absorptive. Present knowledge indicates that the cerebrospinal fluid is produced by the choroid plexuses of the lateral, third and fourth ventricles. The fluid leaves the lateral ventricles through the foramina of Monro and makes its exit from the third ventricle through the aqueduct of Sylvius. There are three outlets from the fourth ventricle: the foramen of Magendie and the two foramina of Luschka. Gaining access to the subarachnoid space the fluid eventually finds its way to the cerebral convexities and is absorbed into the venous circulation through the arachnoid villi,

many of which are located along the large venous sinuses, especially the superior sagittal sinus. Though hydrocephalus might occur as the result of increased fluid production, this is probably not a very common cause of the condition. Obstructions to the foramina of Monro, the aqueduct of Sylvius or the foramina of Magendie and Luschka give rise to internal (non-communicating) hydrocephalus. Obstructions in the subarachnoid channels may prevent fluid from reaching the absorptive mechanism producing communicating hydrocephalus. Finally, the absence or defective development of the arachnoid villi (pacchionian granulations in the adult) produces an absorptive (communicating) hydrocephalus.

The appearance of hydrocephalus in some cases of myelomeningocele has been explained by an anomalous location of the cerebellum, medulla and upper cervical cord, described as the Arnold-Chiari malformation. In 1935 Russell and Donald<sup>4</sup> reported several cases of this malformation and suggested that it constituted the mechanism of internal hydrocephalus in cases of spina bifida. Recently D'Errico<sup>5</sup> has had some success in relieving hydrocephalus in such cases by suboccipital decompression and cervical laminectomy. That the absorptive mechanism for cerebrospinal fluid may be responsible for the hydrocephalus is suggested by the apparent complete absence of arachnoid villi at postmortem examination in one child in the New Haven Hospital series.

The treatment of hydrocephalus should be based upon an accurate knowledge of the particular etiological factors involved. This information may be derived from ventriculographic studies, sometimes combined with encephalography. Aside from the procedure recently advocated by D'Errico in the Arnold-Chiari malformations, there are two general types of surgical approach for the relief of hydrocephalus. In those cases in which the hydrocephalus is due to an obstruction in the aqueduct of Sylvius, third ventriculostomy after the method of Dandy<sup>6</sup> or Stookey and Scarff<sup>7</sup> may be effective in short-circuiting the fluid from the third ventricle to the basal cisterns. In those cases in which an absorptive defect is present or in which the obstruction occurs in the subarachnoid space, it is more feasible to attempt to reduce the secretion of cerebrospinal fluid by direct attack upon the choroid plexuses. A considerable decrease in



fluid production may be obtained by fulguration of the choroid plexuses of the lateral ventricles. Dandy<sup>6</sup> has recently advocated additional fulguration of the choroid plexus of the fourth ventricle when the more conservative procedure is not sufficiently effective. The results obtained by Putnam<sup>8</sup> following coagulation of the choroid plexuses of the lateral ventricles for hydrocephalus are rather encouraging and it appears likely that this procedure will be used more frequently in the future.

The results of choroid plexus operations in eighteen consecutive cases from the New Haven Hospital have been analyzed. (Table 2). These include earlier surgical attempts at fulguration of the choroid through a ventriculoscope and excision of the choroid plexuses, as well as the more recent and more satisfactory procedure of open fulguration of the choroid. Twenty-two operations were carried out upon the eighteen patients with a case mortality of 42%, operative mortality 36%. Seven patients were improved; three were unchanged; and a fatality was directly or indirectly related to the operation in eight instances. Five of these patients had hydrocephalus associated with myelomeningocele. In this group the results were rather unsatisfactory: improved one, unchanged one, operative fatality one. It is interesting that the case mortality of 42% is approximately the same as that reported for repair of meningocele and myelomeningocele by Cutler<sup>1</sup> fifteen years ago. It is not unlikely that the operative mortality for hydrocephalus may be similarly reduced in the next fifteen years.

TABLE 2

### Results of Choroid Plexus Operation in General

Cases . . . . .	18
Operations . . . . .	22
Improved . . . . .	7
Unchanged . . . . .	3
Operative Fatality . . . . .	8
Case Mortality . . . . .	42%
Operative Mortality . . . . .	36%

### Congenital Tumors

Brief mention should be made of the congenital tumors of the central nervous system. Craniopharyngioma is the most common congenital tumor of the brain and accounts for about 5%

of all brain tumors. The symptoms are referable to pressure upon the optic nerves or optic tracts, pituitary deficiency, and increased intracranial pressure. Symptoms may not be recognized until the second or third decade of life or even later. The frequent occurrence of calcification within these tumors makes x-ray diagnosis possible.

Congenital tumors of the spinal cord are usually teratomas and may extend for a considerable distance in the spinal canal. Symptoms may be present at birth or make their appearance at a later date, but the most important diagnostic factor is the progressive loss of neurological function, usually beginning in the lower extremities. One case of this type recently reported from the New Haven Hospital<sup>9</sup> extended from the 4th cervical to the 2nd sacral vertebra. In this case repeated attempts at lumbar puncture were unsuccessful since the spinal canal was completely filled with tumor. Neurenteric cysts are rare congenital teratomatous tumors in the sacral or coccygeal region. They are usually encapsulated and surgical excision is indicated if symptoms are present or growth is occurring.

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## Discussion of Papers of Drs. Kelly, Neuswanger, Griswold and German

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In his review of Dr. Kelly's paper on the Problem of Cleft Lip and Cleft Palate Dr. Lanman stressed the following points;

1. That hare lip does not call for immediate surgical treatment unless there is involvement of the maxilla by the defect, although operation on the lip is preferably done at 3-6 weeks.

2. That the seasons of upper respiratory infections are important considerations in determining the time of operation.

3. That if a protruding intermaxillary bone and hare lip and cleft palate coexist, early treatment of the former is indicated; removal is never to be performed.

4. That pediatric aid is of great importance in the pre and post operative care.

5. That if hare lip and cleft palate coexist, treatment of the former should be carried out first, and that if a period of about one and a half years is allowed to elapse, a partial narrowing of the palatal defect will occur, thereby facilitating the final closure.

In discussing Dr. Neuswanger's paper on Urogenital Deformities, Dr. Lanman made the following points:

1. That circumcision for phimosis should be performed after the child is out of diapers and the likelihood of ammoniacal irritation of the operated area is decreased and before he enters school. He stated that ammoniacal irritation is thought to cause stricture of the urethral meatus, but more frequently it brings about obstruction there by crusting that it causes.

2. That the endocrine treatment of undescended testicle should not be accepted unreservedly until the effect of this measure on fertility in later life is determined.

3. That incontinence, in children, frequently subsides spontaneously, but that failure to do so is a clear indication for complete urological investigation to exclude the possibility of congenital defect in the urinary tract, especially if there is also pyuria.

4. That an important cause of distension of the bladder and incontinence in infants and children is the presence of an obstructing valve in the posterior urethra and that the symptoms may be due to an over distended bladder.

In his discussion of Dr. Griswold's paper on Congenital Orthopedic Deformities, Dr. Lanman stressed the early recognition of congenital orthopedic deformities such as talipes, torticollis, and dislocation of the hip, as important in securing the best possible treatment. He emphasized the advantages of early treatment as being less severe on the patient, as it consists of manipulations rather than operative intervention, and advised that the possibility of these conditions be kept in mind when a new-born child is examined.

He also advanced the idea that the education of parents in the recognition of orthopedic deformities in their children is practical and advantageous.

In discussing Dr. German's paper on Management of Congenital Defects of the Nervous System, Dr. Lanman reemphasized the serious and too-often hopeless nature of cases of congenital defect of the nervous system, and the necessity for early recognition. He questioned the desirability of operation on myelomeningocele, even in the absence of hydrocephalus or drainage of spinal fluid, in view of the associated paralysis of the parts below the site of surgical intervention.

He also laid stress on the recognition of the conditions already enumerated and the extent to which they interfered with cord function by

1. Pain evaluation, with parallel estimation of the degree of motor paralysis.
2. The status of the vesical and rectal sphincters.
3. Bulging of the perineum.
4. Eversion of the rectum.
5. Presence or absence of constant dribbling.



## Medical Air Raid Preparations in England

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The British Empire, particularly England and Scotland are aroused. The past three months have witnessed a unique development in national preparation for a defensive war, based on technocracy. Every arm for home protection has become of vital importance to the Englishman. From experiences in Spain, Abyssinia, China and Albania have come strategic data on which a defense can be built against the barbaric though modern air raids.

Among the many important factors there appears, near the top, the necessary medical preparations on a tremendous scale not appreciated by the average citizen. As an eye witness during the past few weeks, the author was able to gain first hand information on the vastness and comprehensiveness of these "Air Raid Preparations" in the British Isles. Authorities state that 15 minutes from the time raiding bombers reach the channel they will be over London.

As the liner approached Southampton, the numerous navy patrol boats put in their silent, ominous appearance. As each glided past, the lookout, no doubt, recorded all activities of the many nationals passing through the channel. These blue gray war weapons were in greater numbers than observed on other visits to the Island Kingdom. Many planes constantly passed over head as the craft entered the harbor. The customs were particularly strict with police officers in profusion about the pier. Probably the current Irish terrorism in England might account for the Bobbies in such numbers. The boat train, on the way to London, passed through a number of localities where many planes were housed or under construction. Hangars were camouflaged and buildings scattered rather than grouped.

On reaching the metropolis of London, huge

signs greeted the eye — "WE'VE GOT TO BE PREPARED" and "NATIONAL DEFENSE — IT'S UP TO YOU" — war slogans of 20 odd years ago. Nelson's monument, the delight of every English schoolboy, carries on its tall column a blazing sign — "IT'S UP TO YOU." Every theater, cafe or pub has stacks of leaflets calling on the citizens to offer themselves for voluntary auxiliary work — driving ambulances for the woman — blood donors, fire fighters, patrols or balloon handlers for the men. On corners are street signs — "TO THE TRENCHES." Each week, through the mail, the people receive pamphlets containing instructions on rendering homes gas proof; how to build a bomb proof shelter; what to do in case of a raid, fire or muster. House wives are advised to lay in a two weeks' extra supply of canned stuff "because you might find it difficult to obtain food if an emergency should arise."

What is this emergency? The Englishman is being aroused to a danger that the government believes eminent. Through unusually sensible channels, the minds of Mr. and Mrs. Citizen are being prepared for the worst. Everyone is familiar with the new conscription, the huge armaments under construction and the constantly changing international situation. The press is filled with these bits of news but through more subtle ways the English are stirred to expect anything. This is a highly satisfactory state of mind for the government. Thus is created a background which will stand any kind of shock, such as greater concessions to the aggressor nations or even war. Everyone talks of the situation, constantly repeating the same phrases, "We will be next," "We have just 15 minutes" or "Now we are dealing with a crazed man." Of course, the theaters are crowded as usual; traffic goes on just the same. No one postpones his holiday and the travel people complain bitterly that the

American tourist traffic has fallen off over 50 per cent.

Mr. Elliott, the Minister of Health in Mr. Chamberlain's cabinet, has divided the country into medical districts with every physician assigned to a post in the scheme of affairs. This plan calls for each physician to present himself at a pre-arranged station immediately upon the creation of an emergency. Since two thirds of the population of every large urban area, during or immediately after the first air raid, will be transported to pre-arranged quarters in the surrounding country, medical services must accompany them. All private practice of medicine will cease to exist and all physicians will become employees of the government either on a full or part time basis. The scale of salaries to be received has been determined, beginning in the highest brackets with \$7000 down to physicians who will receive \$2.00 an hour on a part time basis. The average full time physician will receive about \$3200 per year. All specialists have been assigned to man hospitals or large concentrations of the evacuated two thirds of the people. Every metropolitan hospital becomes an emergency hospital. Wooden hutments, camp hospitals, private buildings and tent towns are being erected in the country surrounding large cities. When the warning sirens scream, all transportation, by prearrangement, will concentrate at certain points to evacuate hospitals, institutions, schools and the like. All old people, all children and many of their mothers make up two thirds that must be evacuated. There will be left in the large cities only the necessary workers to man public utilities, essential offices, functions of the government, food handlers, fire fighters and all important medical personnel to care for the casualties incidental to the raid.

With two thirds of the metropolitan population thus carried out of the cities and scattered over the country side, the remaining one third will eventually have sufficient protection from falling debris and bursting fragments within the concrete trenches that are now under construction in all of the parks. London is farthest ahead in this regard with every park sprouting stone burrows. Protection is, however, not afforded from direct hits. Casualties will be inevitable. First aid will be of tremendous im-

portance because of the terrific effect of the modern aerial bombs.

During the author's visit to Edinburgh, the first meeting was held of all physicians, numbering some 200 to 300 from the community. Sir John Fraser, Professor of Surgery at Edinburgh University, addressed the meeting on the expected casualties and technic of first aid. The seriousness with which each physician conducted himself was striking. Sir John described the expected intense shock from hemorrhage produced by the bursting of a modern aerial bomb whose casing would be marked off in small squares, permitting a veritable hail of small, sharp fragments. These will produce multiple deep wounds, any one of which might sever an important artery. A new tourniquet, designed for rapid application and which is to be applied as near the source of hemorrhage as possible, was discussed. Because of the tremendous loss of blood expected and the universally acknowledged use of blood as the best treatment in shock, registered blood donors become a vital part in shock treatment. This would be administered only in hospitals.

The new gases and their effects were discussed and everyone was cautioned to stow his gas mask with care. A particularly startling effect of a new high explosive bomb was explained. This bomb can produce death by concussion, without wounding, at a distance of 400 yards. The overwhelming concussion sends the air and gases under tremendous pressure into the respiratory tract and produces death by multiple hemorrhages within the lungs and sinuses. Similar meetings are being held weekly all over the British Isles, instructing physicians in their anticipated duties and keeping them informed of governmental preparations.

The reality of an air raid was demonstrated to the author on two occasions, one in Edinburgh and again in Manchester, during pre-arranged trial "black outs." Every light was turned out and the patrol Bobbies wore luminous breast plates and gloves. Small ultra violet lights adorned corners for traffic control. It is surprising how gruesome a vast city becomes when it is completely darkened and the sky is streaked with shafts from search light batteries.

*(Continued on Page 533)*



# State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

## Ratings of the Bureau of Laboratories in the 1938 Evaluation Study

EARLE K. BORMAN, M.S.\*  
Hartford, Conn.

The Committee on Evaluation of Serodiagnostic Tests for Syphilis, appointed by the Surgeon General of the United States Public Health Service, has rendered great service to the states in sponsoring since 1935 nationwide studies to determine the relative efficiency of each participating state laboratory in detecting cases of syphilis by serodiagnostic tests. These studies conducted through the facilities of the United States Public Health Service have been most carefully planned to permit correlation of clinical data with laboratory findings. The purposes, scope and conclusions of the committee have been published elsewhere<sup>1, 2, 3, 4</sup>.

The Bureau of Laboratories of the Connecticut State Department of Health has participated in past studies and it has been found possible by doing so to obtain information on the efficiency of the work not otherwise available. As a result it has been possible to adopt more sensitive tests and to improve the sensitivity of others.

In general, the plan of the studies is to submit annually to each participating laboratory a portion of each of about 300 blood specimens (100 from normal, non-infected individuals and about 200 from cases of syphilis). The cases of syphilis are selected carefully on the basis of clinical data and comprise so far as possible both treated and untreated cases of primary, secondary, tertiary, congenital and asymptomatic syphilis and of neurosyphilis. The participating laboratory makes the tests and reports results without knowledge of the source of the material

which is identified by a number only. All findings are reported as "Positive," "Doubtful" or "Negative." A control laboratory, preferably that of the author of a test, examines the same specimens and reports in the same manner. Each laboratory is then rated both for specificity and for sensitivity on the basis of the results reported.

The physicians served by the Bureau of Laboratories should be informed of the efficiency of the tests used in comparison with certain control laboratories and with other state laboratories. The results of the 1938 evaluation study have been carefully analyzed, as were those of the 1937 series<sup>5</sup>, and are reported herein for that purpose. It will be seen that these studies have enabled the Bureau of Laboratories to make marked improvement.

The 1938 evaluation was based on 100 specimens from normal, non-syphilitic donors and 207 syphilitic donors. Table 1 shows the clinical status of the 207 syphilitic donors. The terms "inadequate" and "adequate" refer to type rather than to amount of treatment.

Whenever possible four tests were performed on each specimen in the Bureau of Laboratories, — Kline exclusion, standard Kahn, Hinton and Connecticut complement-fixation. Out of the 100 specimens from normal, non-syphilitic donors it was possible to do all tests, except the Hinton in some cases. Eighteen were insufficient for the Hinton test after the other tests were made. Of the 207 specimens from syphilitic donors, 206 were examined by the Connecticut complement-

\*Assistant Director, Bureau of Laboratories.

TABLE I. DISTRIBUTION OF 207 SPECIMENS FROM SYPHILITIC CASES BY STAGE OF DISEASE AND TREATMENT STATUS

	Treatment Status				Total
	Un-treated	Inade-quate	Ade-quate	Not Given	
Primary	0	2	18**	0	20
Secondary	1	3*	12**	0	16
Tertiary	24	5	20***	1	50
Congenital	1	2	2	0	5
Neuro-syphilis	12	6*	24***	2	44
Latent	16	12	47	0	75
Total	54	29****	121****	3	207****

\*One case listed as both Secondary and Neurosyphilis.

\*\* One case listed as both Primary and Secondary.

\*\*\* One case listed as both Tertiary and Neurosyphilis.

\*\*\*\* Total given compensates for one or more cases listed under two headings.

fixation test, 205 by the standard Kahn test, 205 by the Kline exclusion test and 190 by the Hinton test.

### Specificity of Tests

1. *Complement-Fixation* — The Control laboratories for complement-fixation tests were those of Dr. Kolmer and Dr. Eagle each obtaining 100% specificity. Altogether there were 33 state laboratories reporting results of complement-fixation tests, of which 23 including Connecticut reported no false reactions. The remaining 10 reported from 1% to 10% false positive and false doubtful reactions.

2. *Standard Kahn* — The laboratory of the author served as control, performing tests on 96 specimens in the normal group without a false reaction. Of 32 state laboratories which entered standard Kahn tests, 24 including Connecticut also obtained specificity ratings of 100%. The remaining eight laboratories reported from 1% to 8.4% false positive and false doubtful reactions.

3. *Hinton* — In Dr. Hinton's laboratory, 99 specimens in the normal group were examined without a false reaction. Eight state laboratories including Connecticut entered Hinton tests and all obtained 100% specificity ratings.

4. *Kline Exclusion* — This test, since it is not a diagnostic test but is ordinarily used as a "screen" test, requires special interpretation.

It is designed for maximum sensitivity and is balanced so delicately that specificity is frequently sacrificed to attain that end. Therefore, it is not entirely fair to discuss specificity ratings without taking sensitivity ratings into account. These will be discussed jointly in a later section. However, in the laboratory of the author and in two state laboratories no false reactions were obtained on specimens in the normal group. Four state laboratories reported from 1% to 10% false reactions. The Bureau of Laboratories obtained three false positive (one 3+; two 2+) reactions and seven false doubtful (1+) reactions out of 100 tests. This was anticipated when the Kline exclusion test was undertaken as a routine "screen" procedure when it was announced in the Connecticut Health Bulletin<sup>6</sup> that non-specific reactions could be expected since the sensitivity had been set so high. For that reason the Bureau of Laboratories had already adopted the policy of reporting only those results by this test which are frankly negative.

### Sensitivity of Tests

1. *Connecticut Complement-Fixation* — This test as performed in the Bureau of Laboratories must be compared with other types of complement-fixation tests since no other laboratory followed the same technique. The 23 state laboratories which successfully met the requirements for specificity ranged in sensitivity from a maximum of 82.7% down to 48.1%. The Bureau of Laboratories stood fourth among this group with a rating of 79.6%. As controls, the laboratories of Dr. Kolmer and Dr. Eagle obtained sensitivity ratings of 78.7% and 77.1% respectively. The remaining 10 state laboratories which failed to attain complete specificity had sensitivity ratings ranging from a maximum of 82.0% down to 49.0%.

2. *Standard Kahn* — The 24 state laboratories with complete specificity obtained sensitivity ratings ranging from 84.0% down to 59.0%. The laboratory of the author, serving as control, obtained a sensitivity rating of 75.0%. The Bureau of Laboratories, using an antigen rigidly standardized against one prepared by Dr. Kahn, obtained a rating of 75.1%, thereby checking the author's laboratory very closely. The eight state laboratories which failed to attain 100% specificity in the normal group had sensitivity ratings ranging from 87.5% down to 73.8% in the syphilitic group.





### Kline Exclusion Test

That the Kline exclusion technique followed in the Bureau of Laboratories is sufficiently sensitive for the purpose it is designed to fulfill has been demonstrated satisfactorily. Its specificity while no greater than anticipated, can probably be improved with benefit to the work especially since in the 1938 series, Dr. Kline obtained a comparable sensitivity without any sacrifice of specificity. Provided Dr. Kline is able to repeat his results in the current (1939) Evaluation Study, our next step appears to be to attempt to improve the Kline antigen used in the Bureau of Laboratories to attain a standard of performance comparable to that of the author. Up to the present no change has been made and the policy of reporting only frankly negative Kline exclusion test results will be continued.

### Discussion

The ratings given above have included as reactors both positive and doubtful results. This has seemed the best manner of presentation since the significance of the doubtful report is different for each technique. Particularly in complement-fixation reactions, doubtful results may be as significant as strongly positive results because of the well-known pro-zone phenomenon. Ordinarily they denote weak reactions.

The results of the study do not lend evidence to show that any one technique or any one type of test is more efficient in every case than any other. This is stressed since such an impression might easily be gained from the few figures given in this report. As a matter of fact the extreme opposite was demonstrated. The most sensitive test, the Kline exclusion, was negative in the author's hands on three specimens when the Hinton test or the Kolmer test gave reactions. Although there were 17 specimens reacting by the Hinton test with a negative Kolmer test, there were three others in which the Kolmer test showed a reaction not found by the Hinton. In three cases Dr. Kolmer obtained a reaction not detected by the Connecticut method while he obtained negative results on 6 specimens reacting to the Connecticut test. In 4 instances the Connecticut complement-fixation test showed reactions on specimens in the syphilitic group which were negative by the Hinton test in Dr. Hinton's laboratory whereas Dr. Hinton obtained a reaction with 13 specimens negative by the Connecticut complement-fixation test. These in-

stances serve to show that while a given test may have a higher average sensitivity than another the reverse may be true on any given specimen selected at random. Furthermore, a test of less average sensitivity may actually give more information with relation to control of treatment than a highly sensitive test.

In conclusion it can be stated unequivocally that the Evaluation Studies conducted through the United States Public Health Service by the Committee on Evaluation of Serodiagnostic Tests for Syphilis have proved of immense benefit to state health department laboratories by furnishing the clinical controls so necessary to gain an idea of the efficiency of methods. The Committee has recommended that the states in turn offer such a service to local laboratories. This cannot be done in Connecticut with the limited budget under which the Bureau of Laboratories must operate. The Commissioner of Health and the directors of the Bureau of Laboratories and Venereal Diseases will be glad to receive expressions of opinion from physicians and laboratory directors on the advisability of or need for this type of service to local laboratories. For the present, Connecticut must be content with taking advantage of the excellent opportunity to improve the tests in the Laboratories of the Department of Health so that a better service to physicians will result.

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## Eastern Europe Today\*

*(From the Special Correspondent of the Journal in London)*

Relations between Hungary and Rumania have become more strained. *The Times* correspondent in Budapest has admirably and fairly reported the growing bitterness of the Hungarian Press respecting the Magyar minority in Rumania. From private sources we have learned that Hungarian official circles are becoming more excited and that a state of tension appears to be in preparation. There is a growing Nazi party in Hungary, the strength of which is often underestimated in London. The masses are moving towards the Nazi creed.

Further South, confusion also persists. Rumanian relations with Bulgaria are still far from satisfactory. This weakens her strategical position, adding to the heavy burden bearing upon her and upon the Western Powers,

The position of Poland is one of extreme difficulty. Almost every aspect of the Polish situation causes inquietude. Her relations with neighbors are either negative or unfriendly. She will not allow a Russian Expeditionary Force to cross her territory even if one is offered. She has no undertaking from Rumania that help would be given. In fact Rumania is extremely unwilling to go to Poland's assistance and, for that matter, Poland is unwilling to help Rumania. The fact is that, if dangers develop in the South-East at the same time as pressure is being exerted in Danzig, it would be impossible for the Polish Army to go to anyone's assistance; if, on the other hand, Poland is threatened at the same time as Rumania finds herself in difficulties as a result of minority problems and pressure from Hungary or Bulgaria, she could not go to the assistance of Poland. Poland can expect no help from Hungary for, although relations between the two peoples are cordial, Germany is doing her formidable best to drive a wedge between their natural interests.

One of the greatest difficulties facing Poland is that she does not know when trouble may come

and what form it may take. First of all there is the possibility of a direct German attack following a demand for far-reaching revision. Secondly, there is the possibility that the Danzigers may by declaration pronounce themselves part of the Reich, in which case Poland would be left to take the initiative, namely to occupy the Free City, after which none can tell what Germany would do, whether she would merely defend Danzig, whether she would occupy the Corridor in compensation and suggest negotiations, or whether she would take the direct general offensive. Thirdly, Poland may be faced with a prolonged period of tension with persistent pressure inside Danzig and growing unrest in the Ukraine, while a diversion of the first magnitude took place in South-East Europe. No one, not even the best-informed observers, knows exactly what will happen, all we do know is that Poland is one of the countries which figures in Germany's calculations.

In the event of anything happening which in time would involve Poland in general hostilities with Germany, she would have to defend no fewer than four frontiers, namely, the German proper, the Slovakian, the East Prussian and the Ukrainian. The latter is perhaps the most serious, for it is an internal one. The possibility of a strategical diversion by Germany via Lithuania and Memel cannot be excluded.

This is a very serious situation for Poland, having regard to her isolated position. She has no friendly foreign hinterland into which she can retire, and she has no adjacent ally from whom she is prepared to accept help or who is in a position to give full succor. No British expeditionary force can be landed. If she makes concessions her independence will be undermined; if she doesn't, even though a general conflagration takes place and Germany is eventually beaten by other and more powerful forces, for the duration of the major part of hostilities her terri-

\*This is the second of a series of articles pertaining to the World situation.

tory will be occupied and her people will be in subjection.

The Poles are highly patriotic and a somewhat excitable race and in moments of tension they use wild words which sometimes lead to reckless actions. It is common talk in sections of the Polish Army that the sooner war comes the better, that Germany could be beaten by Polish forces alone. Although this arises from a gallant spirit which is much to be admired, it is of course misleading. The Polish military situation is not a strong one.

The conclusion to which observers are driven, therefore, is that in order to help Poland, France, with British support, would be obliged to take the offensive in the West and that the inevitable outcome must be a general European war of unpredictable length. The initial decision would however, rest with the French. It is they who would have first to engage their land forces.

The Great Ukraine is a language area, in which live about 45 million people. It is spread over four countries, namely, Russia, Poland, Hungary and Rumania. If it were an independent state it would be the third largest in Europe. This vast territory is one of the richest in the world. On the Dneiper is the largest electrical power plant in Europe which produces more aluminum as a by-product than the whole of France. Small wonder, therefore, that it is of profound interest to Germany. The effective playing of this card would not only undermine at least three countries and probably four, but it would bring the Reich ever nearer to a glittering prize.

After the occupation of Prague when Hungary was allowed to overrun and subsequently annex Sub-Carpatho-Ukraine (Ruthenia) many thought that Germany had abandoned her interest in the Ukraine. That hope was ill-founded. The reasons why Germany allowed Hungary to annex this area are complex and space does not permit a full account of what happened in the spring. It is sufficient to say that the Ukrainian question is again one of great importance not only in relation to Poland but also in relation to more far-reaching issues. In all probability we are nearing the time when the bigger events which Herr Hitler has envisaged will begin to take shape.

It is perfectly true that there was a short period of hesitation in Berlin as to the best tactics to employ, but there was never any doubt that she intended to go ahead in due time. Since last

May the Reich has been busily organizing every sort of Ukrainian agitator. Near Hanover is a camp where some of these are being trained. Former members of the Sitch and representatives of other Groups are to be found here. The finished products are being despatched to different parts of the Ukraine to cause trouble.

The propaganda broadcasts from Vienna in the Ukrainian language have continued for months past, and the whole movement throughout Europe and the U.S.A. is closely linked with various German departments.

After the March crisis certain well-known non-Slav emigrés from the old Russia, as well as representatives of the Ukrainian movement, all of whom work in close touch with Herr von Ribbentrop, visited him and protested that their interests were not being well looked after. They regarded the Hungarian annexation of Sub-Carpatho-Ukraine as an ominous sign. Like many others, they felt Germany might be dropping a card. Among those who visited Herr von Ribbentrop on that occasion were certain Caucasians, Armenians and persons from Central Asia all of whom have excellent reasons for wanting German expansion. All these were concerned lest there should be any hedging about the Ukrainian cause. Indeed, they bitterly reproached Herr von Ribbentrop. The German Foreign Secretary, however, gave them categorical assurances that the events which had disturbed them were due to certain temporary considerations which had intervened but indicated no change whatsoever in Germany's final plans.

That part of Ukraine which is in Poland is largest outside Russia. There are anything from 6 to 7½ million Ukrainians living there. This factor may play a very important part indeed in the whole Polish situation.

The Polish Ukrainians are demanding (1) cultural autonomy, (2) Semi-political autonomy, (3) Secondary education in the Ukraine language, (4) A university at Lemberg, (5) 10,000 civil service posts, i.e. Police, Station-masters, and Post Office officials.

Observers believe that if most of these concessions were made, there would be less restlessness for some time, but whether this view is well-founded or not it is exceedingly difficult to say, having regard to German propaganda, which doesn't encourage compromise.



Many vital moments have come when conciliation and settlement might have been possible but they have been allowed to pass. The best moment, from every point of view, was in March when Germany allowed Hungary to occupy Sub-Carpatho-Ukraine. Directly after this, anti-German feeling began to grow and even became quite high. Some Germans were beaten up by Ukrainians. This lasted for about three weeks and then stopped rather suddenly. If the Poles had acted at this vital moment and accorded even 50% of the Ukrainian demands, their position to-day would be infinitely stronger, but they missed this golden opportunity and it is doubtful whether it will ever recur. Ukrainian feelings are now bitter. They are willing to take sides with anyone who offers them something; as the Poles have offered them nothing at all and they hate the Hungarians, there can be no doubt that they are becoming the willing tool of Germany once again. So far as our information goes, Poland has no intention of making any concessions to this minority.

In the meantime, the Germans are becoming ever more active. The centre of German activity is Stanislawow. Although the Polish police are exceedingly active and try to stamp out as much propaganda as they can, owing to the efficiency of the organization and the determination of Germany, they are not wholly successful.

In the event of war, Poland would no doubt have what is a really important minority completely hostile, one of the objects of which would be sabotage of the oil fields which are vital to Poland.

The Poles are altogether over-optimistic about the Ukraine. In Warsaw there is under-estimation of the danger not only by Polish officials but by foreign observers, who are much too inclined to forget the true nature of this extremely grave problem. There is light-hearted talk about filling up the Ukraine with para-military organizations, and of evacuation. Another reason

for optimism which is freely given is that most of the young Ukrainians are now serving with the colours. If they have been well saturated with anti-Polish propaganda, it is not a very healthy outlook for the divisions in which they are serving.

The dismissal of the Ukrainian problem by all too many observers is another example of wishful thinking and lack of appreciation of modern problems, the power of German propaganda, and the immense appeal of the doctrine of self-determination which is the foundation of Herr Hitler's Eastern policy.

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### WHY EXTRA SALT IS NEEDED IN SUMMER

Two million glands operate at full tilt in summer to keep the body temperature down to normal by a natural cooling system of perspiration and evaporation, Harriet Morgan Fyler, Ph. D., Chicago, declares in her explanation of the need for using extra salt during hot weather, published in the August issue of *Hygeia, The Health Magazine*.

"In the course of this cooling much water is lost," she continues. "With the water go some of the important elements of the blood. Unless special reinforcements are rushed in to take their place, the blood suffers a sort of starvation, hence fatigue and loss of appetite."

A little salt in a glass of drinking water is thus an effective means of combating this loss. Using extra salt on food where one likes it is also a good practice. Many factories provide salt dispensers near the drinking fountains for their employees.

—☆☆—

### GRADUATES OF YALE MEDICAL SCHOOL LICENSED TO PRACTICE

Yale was one of nineteen medical schools whose graduates had no failures before the state licensing boards during 1938. In all, 6,252 physicians were added to the number practicing in the United States.

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## • Editorials •

### BIRTH CONTROL AND THE LAW

No one who knows Judge Kenneth Wynne, and he has a host of medical friends, was surprised at his realistic opinion in sustaining the demurrers in the Waterbury Birth Control Case. Often the legalistic approach to a social problem befores the realism in it. Not so with Judge Wynne, his is a searching intelligence and with fine understanding he said:

"No decent person would deny the laudable objective of morality and chastity which is sought —. The question which must be determined is this; Is a doctor to be prosecuted as a criminal for doing something that is sound and right in the best tenets and traditions of a high calling dedicated and devoted to health? Should he be forced to practice furtively and in stealth rather than give up what his conscience and his honest professional judgment dictate?

"The court has no right to read exceptions into the statute but is convinced that without these proper exceptions the statute is defective on the broad constitutional grounds set up in the demurrers. It would seem most desirable to have judicially determined once and for all a question so heatedly and futilely debated —."

Final decision must be had by an appeal to the Supreme Court of Errors, but no matter what that decision may be, Judge Wynne's opinion will ever remain to clarify an unhappy controversy into which many specious arguments have been injected.

C. B.



### CONNECTICUT HOSPITAL ASSOCIATION JOINS THE JOURNAL

In January 1940 the Journal will appear, not only as the official organ of the Connecticut State Medical Society but also of the Connecticut Hospital Association. Its title will be changed to The Connecticut State Medical Journal. Early in 1939 the Connecticut Hospital Association submitted to the Council of the State Medical Society a formal request that it



be permitted to use the Journal as its official organ. The Council was unanimous in its approval. Arrangements have been made for representation by the Hospital Association on the Journal Board and it is anticipated that in the field of advertising the Journal will profit by its new relationship with the Connecticut Hospital Association. This new enlargement of the Journal's influence in the State is another step of the State Medical Society in its aim to strengthen and coordinate health activities in Connecticut.

The Connecticut Hospital Association, unlike the State Medical Society, is a young organization. Founded in June 1919 at Bridgeport, there were represented at that first meeting twelve hospitals. Dr. Godfrey of Bridgeport acted as temporary chairman, by-laws were adopted and in the slate of officers nominated by a committee and elected by the group we find Mr. W. W. Jones of Bridgeport, president, Dr. Lewis A. Sexton of Hartford and Dr. Simon F. Cox of New Haven, vice-presidents, Miss Grace L. Wolcott of Waterbury, secretary, Miss J. Alison Hunter of New Haven, treasurer.

In 1939 new by-laws were adopted to conform to those of the American Hospital Association and in addition to institutional membership provision was made for personal members. Membership in the Connecticut Hospital Association is now a pre-requisite for membership in the national body. At the present time the Connecticut Hospital Association comprises 33 active institutional members, 40 active personal and 2 associate personal members.

The Editorial Board of the Journal welcomes to its membership, Mr. Sidney Davidson, Superintendent of Grace Hospital, New Haven. As the Journal enters upon its fourth year it is apparent that it is filling a need among Connecticut physicians. It desires to be of more service to the profession. We extend our most cordial greetings to the Connecticut Hospital Association with whose assistance we anticipate an extension in the scope and usefulness of the Journal.



#### A.M.A. INDICTMENT QUASHED!

Justice James M. Proctor, upholding a defense demurrer to indictments, ruled on July 26 that the American Medical Association and its fellow defendants were not engaged in a trade

as defined by the antimonopoly statutes. Counsel for the doctors had contended their activities could not be governed by the Antitrust Law, that they were engaged in a "learned profession" rather than a trade. On December 20, 1938 a District of Columbia Grand Jury, acting on evidence presented by the Justice Department, indicted the American Medical Association, the Medical Society of the District of Columbia, the Washington Academy of Surgery, the Harris County (Texas) Medical Society and twenty-one individual physicians for violation of the Sherman Antitrust Law. These organizations and individuals, the indictment read, were "engaged in a continuing combination in conspiracy in restraint" of trade in hampering the activities of Group Health Association, Inc., for the District of Columbia, an organization established in 1937 to hire physicians and nurses and provide hospital care on a cooperative basis to government employees. Defense attorneys had contended that all their clients' activities were directed solely at the maintenance of the ethics and standards of the profession.

At the headquarters of the Association, officials, including Dr. Olin West, Secretary, and Dr. Morris Fishbein, Editor, said:

"The principles and policies of the American Medical Association do not forbid nor have they ever contemplated any opposition to a well considered expanded program of medical service, when the need can be established; neither is there any fundamental principle or policy which in any manner opposes aid to the indigent when indigence can be established.

"The American Medical Association has always welcomed investigation by any authorized agency of the nature of its organization or of the conduct of its work or of its activities, firmly reliant in the belief that every action taken by the Association has been in accordance with its constitutional organization in the interests of the public welfare for advancing standards and quality of medical service for the American people; and that at no time has it violated the established law of the federal state, or municipal governments of this country. Moreover, by the very nature of its organization, it has preserved constantly the democratic principles on which the Government of the United States is founded and maintained."

## HELP REDUCE MATERNAL MORTALITY

Certainly every physician practicing obstetrics in Connecticut should feel justifiably proud of the low maternal death rate established in the state in 1937. In that year, Connecticut had the lowest maternal death rate per 1,000 live births in the United States registration area, and the lowest state rate ever recorded in this country. The record established in Connecticut in 1937 has been repeated in 1938 according to the provisional report of maternal deaths. The 1938 rate for Connecticut, however, cannot be compared with that of the United States registration area since the latter is not yet available.

In order to further reduce or at least maintain this enviable low maternal death rate, the State Medical Society in cooperation with the State Department of Health is making a study of all maternal deaths occurring in the State. The study constitutes a review of the case histories of women dying from maternal causes, and it aims to learn what factors seem responsible for the deaths and whether some of these factors may be controlled to prevent unnecessary deaths.

This type of study carried on over a period of time should teach us much regarding the weaknesses of our obstetric practices, and should point the way to future improvements.

In order to facilitate this study, the maternity hospitals have been requested to report maternal deaths immediately to the Bureau of Child Hygiene on special forms provided for the purpose. These reports are referred to the Obstetrics Subcommittee of the Public Health Committee of the State Medical Society for follow-up.

A physician having a maternal death outside a hospital is requested to cooperate with the State Medical Society by sending a report of the death to the Bureau of Child Hygiene, State Department of Health, Hartford, Connecticut.

This type of study is a new project in Connecticut, although similar studies in numerous other states have proved valuable. It is hoped that this study, through the cooperative efforts of both physicians and hospitals, will be helpful in maintaining a low maternal mortality and in reducing maternal morbidity in Connecticut.

S. H. O.

## REPORT OF MATERNAL DEATH

Any death associated with pregnancy or childbirth or any death occurring within three months of an abortion or stillbirth is to be reported.

Name of hospital.....

Name of attending physician.....

Name of deceased.....

Date of death.....

Please return to the Bureau of Child Hygiene,  
Connecticut State Department of Health  
Hartford, Connecticut



## PREPARATIONS FOR WAR

Perusal of the articles appearing in the Journal from month to month on the strategic situations in the countries of Europe and Asia and of the interesting account in this issue on "Medical Air Raids in England" cannot but impress the reader with the seriousness of conditions across the Atlantic. That an armament race is on, that many of the smaller nations find themselves in difficult situations and that the practice of medicine is bound to undergo a great change, for better or worse, no one can tell — all this is only too apparent.

We turn to our nation, standing on the sidelines as it does, with a feeling of thankfulness that our geographic arrangement affords us at least a respite from some of the graver issues. The practice of medicine is receiving its share of shaking down in this country and, were the New Deal to be successful in all its machinations against us, private practice might well be expected to pass into the discard. War may be far away from our borders but within there is plenty to enlist the efforts of the most courageous.



# From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street

New Haven

## Governor Appoints A Commission on the Treatment and Care of People Afflicted with Physical or Mental Disabilities

Under authority granted by Special Act 548 passed by the 1939 General Assembly Governor Baldwin has appointed the Commission on the Treatment and Care of People of the State Afflicted with Physical or Mental Disabilities. The members of this Commission are: Chairman, Kenneth Wynne, Esq., New Haven, Judge of the Superior Court; John A. Markham, Esq., Hartford, attorney; Dr. William Hall Coon, Easton, the only physician member of the 1939 General Assembly; Dr. Wilmar M. Allen, Hartford, Superintendent of the Hartford Hospital and Dr. Creighton Barker, New Haven, Secretary of The Connecticut State Medical Society.

The Commission is charged with the study of the problems presented by the physical and mental disabilities of the people of the State and an inquiry into the subject of the expenditures made, or, in the opinion of the Commission, necessary to be made by the State for the prevention of such disabilities and the care of the people afflicted thereby.

At the Governor's request the Commission will first concern itself with a study of the conditions and administration of the Norwich State Hospital for the Insane.

—☆☆—

## Directory of Physicians of the States of New York, New Jersey and Con- necticut

The copy for the new issue of the Directory of the Physicians of New York, New Jersey and Connecticut, which is published cooperatively by the medical societies of those states, went to the printer on August 5th. Many directory cards have been received since that date and

they are of value in the biographical files maintained in this office but changes included on those cards received after August 5th cannot be made in the forthcoming Directory.

—☆☆—

## Work Projects Administration Compensation Panels

The attention of the members of the Society is again directed to the announcement concerning Work Projects Administration Compensation Panels published in the August issue of the Journal on pages 427-428. It seems probable that there are still many physicians who would like to participate in this activity who have not registered with this office and although no definite deadline has been established for setting up the panels it would expedite the work of the office of the Work Projects Administration and this Society if the forms asking to be included in the panel were promptly filed.

—☆☆—

## Council Proceeds Toward the Employ- ment of Full-time Executive Secretary

In accordance with the vote of the House of Delegates at its 1939 meeting the Council has proceeded with the plan whereby the Society would employ a full-time Executive Secretary. A committee of the Council consisting of the Chairman, Doctor Gold, the Treasurer, Doctor Miller and Doctor Murdock was appointed to arrange the details and it is probable that final consideration of the contracts and the budget for the calendar year 1940 will be submitted to a special meeting of the House of Delegates to be held during the Clinical Congress. Members of the House will be formally notified when arrangements have been completed.

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## SECTION ON Orthopedic Surgery

### WORLD CONGRESS IN LONDON

Forty-seven nations were represented at the Fourth World Conference of Workers for Cripples in London, July 16-22. Lord Neufield acted as chairman and contributed to the success of the meetings. It was Lord Neufield who has given many millions for the care and rehabilitation of cripples. Speakers stressed the change of national laws to permit cripples to find employment in government offices. Civil Service examinations in the United States prevent the handicapped from obtaining work with the government. The inconsistency of spending vast sums for the rehabilitation of cripples and then not permitting them to qualify for governmental positions does not seem to disturb the politicians.

Many new ideas were discussed and much value was brought away by those attending. A reception by the Minister of Health and a garden party by Their Majesties, The King and Queen, contributed to the Congress.



### THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

This section is interested in receiving letters from those who have substantiated cases that have received aid from The Foundation. Those who have sought aid and have not received help should also send in their letters stating their case clearly. Letters stating the opinions of physicians concerning The Foundation should be sent to this section. These letters will help demonstrate the medical response to the contemplated work of The Foundation. Do you or do you not see any results of the work in your community? Is the money collected each year in our state returning in dividends of some type that can be analyzed?

### COURSE IN FRACTURE TREATMENT OFFERED BY CONNECTICUT STATE FRACTURE COMMITTEE, A.C.S.

During the Clinical Congress at New  
Haven, September 19-20-21

**First Day**                      **Dr. Sweet, Presiding**  
2:00-2:30

Pathology of Fractures and Fracture Healing  
M. K. Lindsay

2:30-3:00 P.M.

X-ray and Fluoroscopy in Fracture Treatment  
M. D'Amico

3:00-3:30 P.M.

Muscles and Their Actions on Fractures  
R. M. Yergason

3:30-4:00 P.M.

First Aid — Improvised and Special Technique  
E. H. Crosby

4:00-4:30 P.M.

Medicolegal Aspects of Fractures  
J. J. Donohue

**Second Day**                      **Dr. Vickers, Presiding**

2:00-2:30 P.M.

Reduction and Immobilization in Plaster  
P. P. Swett

2:30-3:00

Open Reduction and Fixation    A. S. Griswold

3:00-3:30 P.M. Skin and Skeletal Traction

C. W. Goff

3:30-4:00 P.M. Compound Fractures

D. Patterson

4:00-4:30 P.M. Fracture Problems in Children

J. H. T. Sweet, Jr.

**Third Day**                      **Dr. Patterson, Presiding**

2:00-2:30 P.M. Upper Extremity Fractures

C. J. Gade

2:30-3:00 P.M. Lower Extremity Fractures

M. M. Pike

3:00-3:30 P.M. Fractures of Spine    F. S. Jones

3:30-4:00 P.M. Traumatic Arthritis in Fracture  
Treatment

D. S. O'Connor

4:00-4:30 P.M. Physiotherapy in Fracture

Treatment                      C. M. Brown

### Daily Discussion of Fracture Problems

4:30-5:00 P.M.

First Day—Karl T. Phillips, Conductor

Second Day—Harold W. Wellington, Conductor

Third Day—George H. Gildersleeve, Conductor



## CHANGES IN THE LAW AS REGARDS REQUIREMENTS FOR THE PRACTICE OF NURSING

The combined efforts of doctors, hospital administrators and nurses have brought about changes in the Nurse Practice Act which perceptibly strengthen the means of keeping the unqualified person from caring for the sick and the same time giving the public a means of knowing whether or not the person giving nursing care is licensed by the State. House Bill 606, as amended, was passed by the 1939 Legislature and is now Chapter 355 of the Statutes of the State of Connecticut. Except for specific exemptions listed in the law, all those who for compensation give nursing care to the physically and mentally ill must be licensed as Registered Nurses or as Trained Attendants.

The essential new features of the law include the following:

1. The practice of nursing is defined as (a) the performing, for compensation and under the direction of a licensed physician, of any professional service requiring special education, knowledge and skill in nursing care of those mentally or physically ill and in the prevention of illness; or (b) the performing, for compensation and under the direction of a licensed physician, of any of the simpler procedures required in nursing care of the sick, not involving the specialized education, knowledge and skill specified in subsection (a).

2. The exemptions to the law include the following: the incidental care of the sick by domestic servants or by persons primarily employed as housekeepers, the domestic administration of family remedies or the furnishing of assistance in the case of emergency; persons employed in state hospitals and state sanatoria and subsidiary workers in general hospitals from assisting in the nursing care of patients if adequate medical and nursing supervision is provided; students who are enrolled in accredited schools of nursing and students who are enrolled in accredited schools for attendants from performing such work as is incidental to their respective courses of study; graduates of schools of nursing from nursing the sick pending the results of the first examination for certification scheduled by the board following their graduation, provided

such graduate nurses are working in hospitals or organizations where adequate supervision is provided; graduates from accredited schools for attendants from caring for the sick pending the results of the first examination for certification scheduled by the board following their graduation, provided such attendants are working in hospitals where adequate supervision is provided; any duly qualified registered nurse of another state from caring for a patient temporarily in this state, provided such nurse shall have been granted a temporary permit from said board and provided such nurse shall not represent himself or herself out as a nurse licensed to practice in this state; registered nurses from other states from doing such nursing as is incident to their course of study when taking post-graduate courses in this state which are approved by said board; the nursing care with or without compensation or personal profit, in connection with the practice of the religious tenets of any church by adherents thereof, provided such persons shall not otherwise engage in the practice of nursing within the meaning of this act; and the care of the sick in their homes by those who do not hold themselves out to be registered nurses or trained attendants.

3. The waiver for certification of trained attendants is open until July 1, 1940. The requirements for the trained attendant license under the waiver include the following: at least twenty-one years of age; good moral character; citizenship in the United States or to have legally declared intention of becoming one; resident in Connecticut for three years prior to July 1, 1939, three or more years of experience in the care of the sick for remuneration prior to July 1, 1939; endorsement of application by two physicians licensed in Connecticut and by two persons by whom he or she has been employed. The fee for the license under the waiver is five dollars.

4. Eligibility for trained attendant license after July 1, 1940, requires that the applicant be twenty-one years of age or over, of good moral character; a citizen of the United States or to have legally declared his or her intention of becoming one; to have received a certificate from an institution approved by the Board of Examiners for Nursing which gives a course of not less than twelve months' instruction in the

care of the sick as prescribed by said board, or its equivalents as determined by said board, and to take and pass examinations given by said board. The fee for trained attendant license by examination is five dollars.

5. Section 17 states that "\_\_\_\_\_, no person shall practice nursing as defined in this act in this state unless registered or certified as herein provided. Any person who shall violate any provision of this act or who shall wilfully make false representation to the board of examiners for nursing shall be fined not more than one hundred dollars\_\_\_\_\_."

The changes noted will affect those employed to give nursing care in convalescent homes, private hospitals and sanitariums, offices, camps, and industry. Although the law exempts from licensing those giving nursing care to the sick in their homes — providing they do not hold themselves out as registered nurses or as trained attendants — many working in such a capacity will wish to secure a license as a trained attendant under the waiver. We hope that those satisfactorily meeting the needs of the sick and having the qualifications required will be informed of the waiver for trained attendant licensing. May we therefore solicit your help in informing eligible applicants of the waiver and of the requirements for same. When questions arise we shall be glad to have you refer them to this office.

Agnes K. Ohlson, Secretary,  
Conn. State Board of Examiners for Nursing,  
State Office Building, Hartford, Conn.



### GRADUATE FORTNIGHT OF NEW YORK ACADEMY OF MEDICINE

The Endocrine Glands and Their Disorders will be the subject for consideration at the Twelfth Graduate Fortnight of the New York Academy of Medicine, October 23 to November 3, 1939. Round Table Conferences will be held some of the mornings and Hospital Clinics in the afternoons. The evening meetings will be addressed by such eminent authorities as Doctor Collip of McGill University, Doctor Sevringhaus of University of Wisconsin and Doctor Cannon of Harvard University. Registration is \$5.00 and check should be sent to Doctor Mahlon Ashford, The New York Academy of Medicine, 2 East 103 Street, New York, N.Y.

## Our Neighbors

### NEW YORK

A decision that may have far reaching effects among members of the medical profession, if sustained by the higher courts, was handed down on July 6 by Municipal Court Justice Nicholas M. Pette, in Queens, who ruled that a physician who maintains his office in his home is entitled to residence telephone rates. The New York Telephone Company was ordered to refund to a former president of the Queens County Medical Society the sum of \$131.56 which represented the difference between residence and business rates paid over a certain period.

### - NEWS -

#### *from County Associations*

### Fairfield

An excellent group of speakers is being arranged for the fall and winter meetings of the Fairfield County Association. The program committee consisting of Doctors D. Chester Brown, J. L. Vickers, R. H. Lockhart and J. G. Booe, and the secretaries of the local medical societies have arranged a symposium on the general subject of "Infection." Dr. Milton C. Winternitz, Professor of Pathology at Yale, will speak at the opening meeting in Greenwich on October 17th. His subject will be, "Infecting Agencies and Pathology." Subsequent meetings will be held with each local society in the county.

In the past the first fall meeting has been planned to combine an outing and a scientific session. This year there will be two meetings, the one at Greenwich already mentioned will be devoted to the subject announced. Preceding this the Stamford Society will be host to the county groups at an outing to be held at the Hubbard Heights Golf Club, West Broad Street, Stamford.



Congratulations to Dr. and Mrs. William A. Sunderland on a visit from the stork, and to Dr. Felix F. Tomaino on becoming a benedict.

### Hartford

Dr. Charles W. Goff has just returned from London, England, where he attended, as a delegate, The World Conference of Workers with Crippled Children. Dr. Goff represented the Connecticut State Society for Crippled Children.

Dr. Oran A. Moser, Health Officer of Rocky Hill, will have as Assistant Health Officer, Dr. Edmund Kelly.

Dr. Charles Mirabile of Hartford successfully qualified by examination held recently at White Sulphur Springs, West Virginia, for a certificate from the American Board of Neurology.

Dr. Daniel E. Shea, formerly director of the Bureau of Venereal Diseases of the Hartford Department of Health, working on a part-time basis, was promoted full-time director.

### New Haven

Doctor Paul W. Preu of New Haven addressed the Rhode Island Society for Neurology and Psychiatry recently on "Symptomatic Psychoses with Special Reference to Bromide Intoxications" and Doctor Edwin F. Gildea of New Haven addressed the same society on "Relationship of Vitamin Deficiencies to Neurological and Psychiatric Problems."

The honorary degree of Doctor of Science was conferred upon Professor Ira V. Hiscock of the School of Public Health, Yale University, by Wesleyan University at its 107th Commencement June 18. Professor Hiscock, a graduate of Wesleyan in the class of 1914, has been a commissioner of the New Haven Board of Health for more than eleven years.

Doctor Jacob Nodelman of New Haven has successfully passed the examinations held on May 15, 1939 and has received the certificate from the American Board of Ophthalmology.

### New London

We have had the misfortune to lose Dr. Leon LaPierre of Norwich, Conn. He died on Aug. 7th and was buried at Maplewood Cemetery on August 9th. Dr. LaPierre was 63 years of age and served for many years on the staff of the Wm. W. Backus Hospital in the Eye, Ear, Nose and Throat department. He also carried on a private practice with his brother, Dr. Arnaud LaPierre.

Dr. Lewis Sears of Norwich is taking a special course in cardiology under Dr. Paul White of Boston.

Dr. Solam Segel is studying under Dr. Joslin of Boston and he is to be in charge of the ward diabetic cases at the Backus Hospital under Dr. Freeman when he has completed his special training.

A son was born to Dr. and Mrs. Harold Higgins on July 8, 1939.

## The Doctor's Office

John W. Buckley, M.D., announces the removal of his office to 2080 North Avenue, Bridgeport, where he will continue the practice of pediatrics.

Maurice F. O'Connell, M.D., announces the removal of his office to 50 Farmington Avenue, Hartford. Practice limited to traumatic and orthopedic surgery.

Andrew Taylor, M.D., announces the opening of his office at 179 Allyn Street, Hartford. Practice limited to disease of anus, rectum and colon.

Joseph Bentley Hollinshead, M.D., announces the opening of an office for general practice of medicine at 1018 Farmington Avenue, West Hartford.

Joseph J. Lankin, M.D., announces the opening of an office for the general practice of medicine at 266 Wethersfield Avenue, Hartford.

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## Letters to the Editor

### TRAINING OF OPTOMETRISTS

To the Editor:

Optometrists have received some attention in the editorial column of the Journal of the Connecticut State Medical Society.<sup>1 2</sup> Further data is available to explain the general disapproval of the majority of physicians for Optometry. Superficial consideration of this grave problem may have led certain individuals to be more lenient in their attitude towards Optometry than the facts warrant. A brief survey of the situation from the standpoint of the educational standards of optometrists, should be of value to all interested in this problem.

Before we consider the optometrist's qualifications, let us admit that optometrists are practicing medicine, so far as concerns the eyes. They deal with an organ whose loss from whatsoever cause becomes a serious handicap. They are in the business of improving the eye-sight. They are called "doctor" and many people think they have the medical background which their title implies. Optometrists should be classed among other Cultists, who attempt to practice the healing arts, including preventive medicine, but who have insufficient medical training. The logical classification for the optometrist is as a technician, similar to the x-ray, or laboratory technician. For the visual safety of the general public the work of optometrists should be under the direction of ophthalmologists.

Optometrists are playing a far more important role in the treatment of eye conditions today than their abilities warrant. Organized Optometry has taken advantage of every opportunity to advance the members of its groups. Financially powerful, Optometry is now the most potent cult with which medicine has to contend. The ideals of optometrists, as a group, do not have anything in keeping with the Hippocratic Oath. It has been said that Optometrists are interested only in the sale of merchandise.

For non-medical appraisals of Optometry, all physicians should be acquainted with the article by R. W. Riis, "Optometry on Trial."<sup>3</sup> An-

other illuminating article was written for the the book "America Now."<sup>4</sup> The latest and best survey of Optometry, by an ophthalmologist was done in 1936 by C. W. Rucker, M.D.<sup>5</sup> At that time he noted that there were only 8 schools in this country teaching Optometry, and listed them as follows:

1. The Philadelphia Optical College, 3 month "personal extension course of home study," fee \$25., handsome diploma conferring degree of Doctor of Optics; fee \$50., degree of Doctor of Optometry. Graduates accepted in but few states.
2. Northern Illinois College of Optometry in Chicago, founded in 1873, over 10,000 graduates. Originally course covered 3 months, in 1936 extended to cover 3 years, degree of Doctor of Optometry.
3. Pennsylvania State College of Optometry, 3 year course, degree of Doctor of Optometry.
4. Massachusetts School of Optometry, 3 year course, degree of Doctor of Optometry.
5. Los Angeles School of Optometry, 3 year course, degree of Doctor of Optometry.
6. Ohio State University, 4 year course, degree of *Bachelor of Science* in Optometry.
7. Columbia University, 4 year course, degree of *Bachelor of Science* in Optometry.
8. University of California, 4 year course, degree of *Bachelor of Science* in Optometry.

The present higher educational standards are of recent origin and contrast markedly with the schools of optometry of the early 20th century. The higher standards in the schools of Optometry probably arise from the fact that certain universities have inaugurated a 4 year course in Optometry.

Ohio State, Columbia University and the University of California all offer 4 year courses leading to the degree of Bachelor of Science in Optometry. None of the universities offer the degree of Doctor of Optometry. The first 2 years are under the auspices of the physics departments of those universities and the last 2 years are devoted to Optometry.

It is notable that no medical school courses are incorporated in any of the Optometry schools. According to Dr. Rucker's report there were 20,000 practicing optometrists in 1936. At that time the University of Ohio State had graduated



from the 4 year course in Optometry 144 (from 1916 to 1935); Columbia had graduated 126 (1926 to 1935); the University of California had graduated 65 (from 1925 to 1936). All 335 of these men were Bachelors of Science in Optometry, not Doctors of Optometry. They were hardly a drop in the bucket of 20,000. Dr. Rucker estimated that another 1200, at the most, had been graduated as Doctors of Optometry from the schools numbered 2, 3, 4, and 5, making a total of 1500 practicing optometrists of more than 2 years actual training. It appears that less than 10% (2000) of the practicing optometrists (20,000) had more than 2 years education in preparation for their profession.

Exact figures were not available on the number of optometrists who had been trained up to 2 years. Dr. Rucker estimated from his carefully obtained figures that 25% of the optometrists had been trained at least 2 years.

What about the 15,000 Doctors of Optometry who had between 3 months and 2 years training? In the editorial mentioned above the suggestion was made that a 4 year course in a university adequately trained a man to fit glasses and measure muscle balance. If we admit that premise only 335 optometrists in the entire country would be considered qualified by that editorial writer of the Journal of the Connecticut State Medical Society (335 in 1936).

Physicians have no power of determining the standards that legally allow an optometrist to practice. The majority of physicians know little about the education of an optometrist. But any physician can count up the years he spent in study and internship and ask himself how well prepared he was in 2 years, or less, to specialize in any branch of Medicine.

It is interesting to compare the eight schools of Optometry with the ninety-four<sup>6</sup> residencies and curricular courses offered M. D's. who wish to specialize in Ophthalmology. All the fifty-seven residencies except two require previous internship, many require a general internship. That immediately takes a toll of 10 years, at a minimum, (including college, medical school, internship and residency) to educate an ophthalmologist. And even then he has not done enough to meet the requirements of the American Board of Ophthalmology.

What about the 15,000 optometrists of less than 2 years training? Are they competent to see

eyes in the early stage of disease, and recognize that disease? The answer is no.

If the early recognition of appendicitis were entrusted to 15,000 men of such training as the optometrists, the mortality would be multiplied several times. The percentage of blindness in this country is several times higher than it would be if all people were properly examined before fitting glasses. If there are more optometrists than eye specialists in this country, in spite of there being ten times as many schools for M.D.'s as for optometrists, it must occur as the result of the limited training of optometrists.

To be sure, the trend now is to require longer education for optometrists. But at its best (4 year courses) optometry does not educate men medically. No optometrist is qualified to diagnose any disease of the eyes. Of course they attempt to diagnose and treat eye disease, when they think it is present. But the sad fact is that they do not recognize disease until very late, usually not until the patient is well aware of the trouble himself. If eyesight is to be preserved against disease and sometimes if life itself is to be preserved, (intra-ocular melanomas, etc.) disease must be diagnosed as early as possible.

The general physician is responsible for the falling mortality figures in appendicitis, cancer, pneumonia, etc. His success has been due to early diagnosis. Let the family physician consider the benefits of early diagnosis of eye disease and send his patient to the eye physician or ophthalmologist, not to the optometrist. If the optometrist is capable of refracting certain types of cases, after a 4 year university course, which is doubtful, the examination for disease of the eyes should be made at the same time, necessitating consultation with an ophthalmologist.<sup>7</sup>

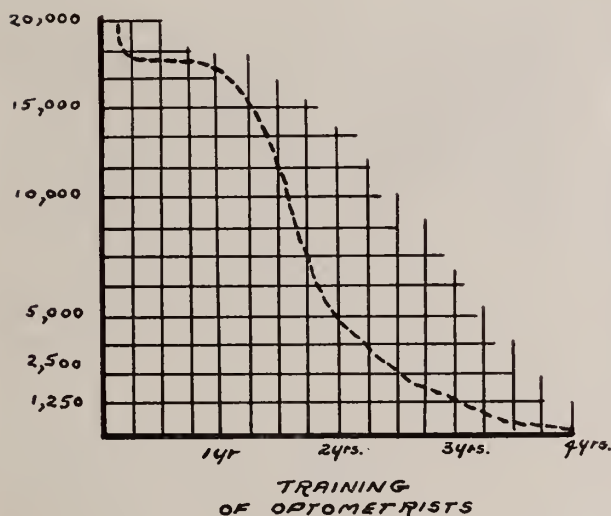
The 1939 Connecticut legislature recently passed a bill extending to four years the required course of study as pre-requisite for the practice of Optometry. The Department of Health is to be congratulated upon thus helping to improve the status of Optometry in Connecticut. But the problem of diagnosing disease of the eye remains, and will remain until the proper medical back-ground is demanded for all those treating the eye in any way.

Very truly yours,  
Henry L. Birge, M.D.

(Continued on Page 523)

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GRAPH: SHOWS NUMBER OF YEARS  
TRAINING PER THOUSAND OPTOME-  
TRISTS. TAKEN FROM FIGURES  
COMPILED BY C. W. RUCKER, M.D. (6)



### EXPLANATION OF MEDICAL RE- QUIREMENTS FOR MARRIAGE LICENSES IN NEW YORK STATE BY COMMISSIONER OF HEALTH

To the Editor:

The New York State Legislature in 1938 passed a law requiring a physical examination including a standard serological test for syphilis on all applicants for marriage licenses within the state.

Several instances have been called to my attention in which residents of other states have had difficulties in securing marriage licenses in New York State because of misinterpretations of the law by themselves or their examining physicians. In order that such inconveniences may be avoided, I should greatly appreciate it if you would, through your Journal, inform the medical profession of your state of the provisions of the New York law.

That part of the act as amended and effective July 1, 1939 referable to those examinations reads as follows:

"Physician's examination and serological test of applicant for marriage license. 1. Except as herein otherwise provided, no application for a marriage license shall be accepted by the town or city clerk unless accompanied by or unless there shall have been filed with him a statement or statements signed by a duly licensed physician or by a commissioned medical officer of the United States army, navy or public health service that each applicant has been given such examination, including a standard serological test, as may be necessary for the discovery of syphilis made on a day specified in the statement, which shall not be more than the thirtieth day prior to that on which the license is applied for, and that in the opinion of the physician the person therein named is not infected with syphilis, or if so infected is not in a stage of that disease whereby it may become communicable."

The law further states that "a standard serological test shall be a laboratory test for syphilis approved by the state commissioner of health and shall be performed by the state department of health, or in the city of New York by the department of health of such city, or at a laboratory approved for this purpose by the state department of health, or in the city of New York, by the department of health of such city."

I offer the following comments relative to its interpretation:

1. A duly licensed physician means any physician duly licensed to practice medicine in the state in which he resides or in which he maintains his office.

2. The date of examination is interpreted to mean the date on which the specimen of blood is taken.

3. The state commissioner of health and the state department of health referred to mean



commissioner of health of the state of New York and the New York State Department of Health.

4. Laboratory tests made as a part of premarital examinations for persons applying for marriage licenses in New York State, outside of New York City, as well as the laboratories in which these tests are performed, must be approved by the New York State commissioner of health. For administrative reasons laboratories within New York State only have been approved for tests on applicants for licenses in the state exclusive in New York City.

5. The Commissioner of Health of the city of New York has approved certain out-of-state laboratories for the performance of serological tests on persons applying for marriage licenses in New York City. Requests for information concerning laboratories approved by the New York City Department of Health should be addressed to that Department at Worth and Centre Streets, New York City.

#### **Outline of procedures for examination of out-of-state applicants for marriage licenses in New York State exclusive of New York City**

1. Any physician duly licensed to practice medicine in the state in which he resides or in which he maintains his office may perform the necessary physical examination.

2. The specimen of blood must be sent to an approved laboratory in New York State. It is suggested that specimens be sent to the Division of Laboratories and Research, New York State Department of Health, New Scotland Avenue, Albany, N.Y., where examinations will be made free of charge.

3. The specimen should be labeled "for premarital examination."

4. The use of air mail is recommended when the specimen must be sent a great distance.

5. Upon completion of the test the laboratory will send the physician, in addition to the usual laboratory report, a certificate to the effect that the serological test was performed as a part of a premarital examination.

6. If, in the opinion of the examining physician, the applicant is free from syphilis or does not have the disease in a stage which may become communicable, he should complete the certificate as indicated thereon.

7. The certificate is given to the applicant

who will submit it to the clerk when the marriage license is applied for.

If those procedures are followed, there should be no difficulty in obtaining the license.

For further information relative to the marriage of persons in New York State, exclusive of New York City, communications should be addressed to the Division of Syphilis Control, New York State Department of Health, Albany, N.Y.

Very truly yours,

Edward S. Godfrey, Jr.

Commissioner of Health

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#### **AN HONEST OPINION**

August 14, 1939.

To the Editor:

I feel that the Journal has reached a new low in its recent articles on insurance, and the first (and I fear not the last) article pertaining to the world situation in the current issue.

In my estimation the latter is an extremely unscholarly exposition of a subject which has no place in a medical journal. Furthermore, I think that it is discourteous to the readers to conceal the name of our distinguished special correspondent in London. I hope that you will inform me concerning the reason for this article and the identity of its author.

Very truly yours,

Paul H. Laviertes, M.D.

Assistant Professor of Medicine

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#### **A SUCTION CAP FOR ROTATION AND DELIVERY OF FETAL HEAD**

Doctor Richard Torpin in the Journal of the Medical Association of Georgia, June 1939, reports the use of a device consisting of a rubber concave helmet that fits the fetal head to be used in place of forceps for rotation and delivery. It has a tubular connection from the concave surface to a vacuum pump fitted with a mercury gauge to measure the degree of vacuum. The unique feature of this model is a method of preventing the scalp from blocking the opening to the pump by a series of lugs rather evenly distribute over the concave surface. The indications and conditions for the use of this device are identical with those in the application of obstetrical forceps.

# 147th Annual Meeting

## Proceedings — House of Delegates

(Continued from Page 442)

### WEDNESDAY MORNING SESSION

May 24, 1939 (Cont'd)

#### REPORT OF THE COMMITTEE ON MEDICAL EXPERT TESTIMONY

The Committee begs to submit the following report: Since our last report, May 25, 1938, your Committee has continued to function as previously. Contact with the Special Committee of the State Bar Association has been maintained and future conferences are planned.

This report is one of progress. At this time we had hoped to bring to you something in the way of a concrete recommendation, but this whole subject of medical expert testimony is very involved and it is going to be necessary to have the cooperation of the State Bar Association to formulate any effective plan. It is the belief of your Committee that at the Annual Meeting in 1940 we shall be able to bring you a final report with our recommendations.

OTTO G. WIEDMAN,

Chairman.

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#### REPORT OF THE COMMITTEE ON COOPERATION WITH THE YALE UNIVERSITY SCHOOL OF MEDICINE

Mr. President and Members of the House of Delegates:

Two regular meetings were held and no complaints were reported by Doctor Bayne-Jones or Doctor Gold for discussion. At the November meeting Mr. Hamilton, Superintendent of the New Haven Hospital, spoke of the desire and contemplation of the New Haven Hospital to adopt a plan for an all-inclusive weighted day rate for hospital charges. He explained the plan at some length, pointing out that it was in one sense a reversion to the old method of all-inclusive hospital rates. It would replace the present scheme by including nearly all special extra charges in this rate, among these the charge for X-ray.

Doctor Bayne-Jones asked the approval of the Committee to publish a list of opportunities as offered by the Yale Medical School; Doctor Barker suggested that he send it to Doctor Stanley B. Weld, Editor of the Journal.

At the March meeting Doctor Bayne-Jones reported that the post-graduate course in obstetrics given by Doctor Morse and Doctor Thoms is going well and that there are ten students registered. Doctor Zimmerman's course in neuro-pathology and Doctor Winternitz' in pathology are also successful and Doctor Winternitz is making more contacts with other hospitals as regards post-graduate work.

Doctor Bayne-Jones reported that no serious complaints were to be reported on the all-inclusive hospital rate. The City of New Haven has refused to pay the extra dollar charge and consequently the hospital felt the loss of these ward cases. The obstetrical, gynecological

and pediatric departments suffered the greatest loss. It still seems desirable to continue these meetings for the friendly cooperation between the Society and the School of Medicine.

JAMES DOUGLAS GOLD,

Chairman.

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#### REPORT OF THE COMMITTEE ON NARCOTIC DRUG ADDICTION

Mr. President and Gentlemen of the House of Delegates:

At its annual meeting held May 25, 1938 the House of Delegates of the Connecticut State Medical Society voted that the Committee on Narcotic Addiction be directed to prepare and present a bill designed to restrict the sale of barbiturates and other hypnotic drugs to the prescription of licensed physicians.

In accordance with these instructions your Committee has held two formal meetings and there have been a number of informal conferences and considerable correspondence on the subject. Members of the Committee attended a meeting of the Connecticut Pharmaceutical Association and discussed barbiturate legislation.

The drafting of the barbiturate law resolved itself into a compromise between a relatively simple law agreeable to physicians and a much stricter law desired by the pharmacists. Therefore, the wording of the law as submitted to the Committee on Public Policy and Legislation was a compromise which some physicians felt would put too great restriction upon the physician. The pharmacists believed, however, that the law was not strict enough and that the medical profession should be bound by law to keep records comparable with those they keep for opium and other narcotics. The pharmacists were also of the opinion that certain members of the medical profession would dispense large quantities under the law as proposed.

The draft, copy of which follows, was submitted to the Committee on Public Policy and Legislation in December, 1938, together with the opinion that this draft while too strict to suit the desires of many physicians was not strict enough to engage the support of the Pharmaceutical Association. Consequently, the Committee on Public Policy and Legislation has not caused the bill to be introduced.

#### Suggested Law for Consideration in Connecticut, an Act to Regulate the Sale of Barbitol or any Other Hypnotic or Somnifacient Drug.

##### Section 1. Sale at Retail and Physician's Record.

No barbitol or any other hypnotic or somnifacient drug as defined herein shall be sold at retail or dispensed to any person in the State of Connecticut except upon the written prescription of a duly licensed physician, dentist, or veterinarian, and no pharmacist shall dispense any such drug without affixing to the container in which the drug is



sold or dispensed a label bearing the name and address of the pharmacist, the date compounded, and the consecutive number of the prescription under which it is recorded in his prescription files, together with the name of the patient, the name of the physician, dentist, or veterinarian prescribing it, and the direction for the use of the drug by the patient as given upon said prescription of the physician, dentist, or veterinarian, but the provisions of this Section shall not apply to a duly licensed physician, dentist or veterinarian when in their judgment they deem it advisable to dispense a single dose of any of the aforementioned drugs to their patients under their immediate supervision.

#### Section 2. Labels.

No manufacturer, pharmacist, jobber or other dealer in drugs shall sell or have in his possession barbitol or any other hypnotic or somnifacient drug, unless the container bears a label securely attached thereto stating conspicuously in printed words the specific name of the barbitol or other hypnotic or somnifacient drug, and the proportion or amount thereof. Such label shall not be necessary when such a drug is dispensed by a pharmacist upon a prescription and the container is labeled in the manner described in Section 1 herein.

#### Section 3. Definitions.

For the purpose of this Act, the term "barbitol" shall be held to mean and include the salts of barbituric acid, also known as Malonylurea, or any derivative or compounds or any preparations or mixtures thereof and the term "Other Hypnotic or Somnifacient Drug" shall be held to mean and include Sulphonethymethane (Trional), or Sulphonmethane (Sulphonal), or Diethyl-sulphon Diethylmethane (Tetronal), or Paraldehyde or any derivatives or compounds or any preparations or mixtures thereof, and Chloral or Chloral Hydrate or Chlorbutanol or any compounds or mixtures thereof when such Chloral or Chloral Hydrate or Chlorbutanol or compounds or mixtures thereof are to be used internally. The provisions of this Section shall apply to any of the above-mentioned drugs whatever may be the name under which the same may be called or known.

#### Section 4. Penalties.

Any person who shall violate or fail to comply with any of the provisions of this Act shall be guilty of a misdemeanor, and, upon conviction, shall be sentenced to pay a fine of not less than \$25 nor more than \$100.

#### Section 5. Enforcement.

The state department of health, the commissioners of pharmacy, the county health officers in their respective counties, the authorized agents of such officials and the police authorities and police officers in their respective jurisdictions and all state's attorneys, shall enforce all provisions of this Act, except those specially delegated, and shall cooperate with all agencies charged with the enforcement of the laws of the United States, of this state and all other states, relating to narcotic drugs. (FROM CHAP. 138, SEC. 988c, UNIFORM DRUG ACT)

Your attention is called to the fact that the law as submitted does not include other dangerous drugs, such as sulfanilamide, dinitrophenol and benzedrine, which many physicians and pharmacists would like to see controlled. Your Committee has discussed this but as yet does not

believe the time propitious to urge such a "dangerous drugs" law.

Further changes in the Uniform Narcotic Act have been considered, in particular the removal of paregoric from the exempt list. The Committee, however, believes it unwise to further modify the law until sufficient time has elapsed to see how the Act has worked. The Committee also believes it unwise to suggest modifications at every session of the Legislature.

Respectfully submitted:

ARTHUR BLISS DAYTON,

Chairman.



### REPORT OF HOSPITAL COMMITTEE

Mr. President and Gentlemen of the House of Delegates now assembled:

The Hospital Committee begs to report that numerous and sundry meetings have been held during the period since we last reported to you, all with full attendance for which I feel the members should be congratulated.

The Chairman, by virtue of his position, was appointed by Governor Cross to both Committees for the purpose of studying and preparing suitable legislation for the so-called Prepaid Hospital Insurance Plan. The first or large group included Directors of Hospitals, Hospital Executives, The Catholic Bishop of Connecticut, President of Wesleyan and State Colleges, Insurance men, representatives of various existing plans, lawyer, doctors and, most important in many respects, the Insurance Commissioner of the State of Connecticut. The Governor showed his usual keen understanding of the situation and subsequently appointed a smaller Committee to draft a suitable and legal bill for presentation to the Legislature. This group met under the guidance of Dr. Allen of Hartford and with the continued good advice of Mr. Blackall (State Insurance Commissioner). Their recommendations were approved by the larger group and a bill was presented, embodying the principles laid down by the Council and House of Delegates and aiming toward a state-wide uniform contract, legally and financially sound, and fitted to the purse of the man who would naturally expect to pay his physician. (At present writing, this bill has been reported favorably from Committee but has not been passed).

The Council referred several questions during the year and, although numerous meetings were held and much time consumed, little was accomplished.

There have been no joint meetings with the Committee from the State Hospital Association which, I feel, is a mistake, still contending that a close relationship between these associations will be of mutual advantage at all times. Your Chairman has been an accredited delegate to the Connecticut Hospital Association meetings during the past year.

Hospitals throughout the State have been active and in many cases over-crowded. The only outstanding radical change instituted is that at the New Haven Hospital relative to all inclusive rates (a summary of this plan is attached to the report, and will not be embodied as it is probably familiar to most of the gentlemen present).

It is possible at this time to report on impending Hospital Legislation. The Bill requesting funds for can-

cer treatment, the re-allocation of the dependent relative to supporting town, and the re-allocation of State Fund to Hospital in proportion to State work performed, are all pending.

In closing, I particularly wish to thank the members of this Committee for their attendance and interest, together with their helpful spirit of co-operation.

Respectfully submitted,  
H. BERTRAM LAMBERT, M.D.  
Chairman

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#### REPORT OF THE CHAIRMAN OF THE COMMITTEE ON INDUSTRIAL HEALTH

The Committee was organized in September, 1938, and has consisted of the following members and chairman:

Dr. William A. Sunderland, Danbury  
Dr. Richard O'Brien Shea, Bridgeport  
Dr. Benedict N. Whipple, Bristol  
Dr. Donald B. Wells, Hartford  
Dr. John Purney, New Britain  
Dr. Paul W. Vestal, New Haven  
Dr. John S. Dye, Waterbury  
Dr. Cole B. Gibson, "Undercliff," Meriden  
Dr. Clifford Kuh, Chairman, New Haven

The first meeting of the Committee was held in Meriden at the home of Dr. Cole B. Gibson on November 29, 1938. Doctors Joseph Linde and Creighton Barker of New Haven attended on special invitation. The business of this meeting was recorded in a five-page mimeographed report which is on file in the Society's offices and which is summarized below. A copy of the report was sent to all members of the Committee.

In brief it was proposed at this meeting that there be a tripart approach to the problems of industrial health in Connecticut, namely, that the effort be made to win the cooperation of:

- (1) the Bureau of Occupational Diseases of the State Department of Health
- (2) industry, chiefly through the Manufacturers' Association, and
- (3) the physicians of the State.

Since this meeting Dr. Albert S. Gray, Director of the Bureau of Occupational Diseases of the State Department of Health, has been made a member of the Committee.

Concrete suggestions made at the meeting were as follows:

- (1) A health committee for the Manufacturers' Association should be recommended in due time.
- (2) An exhibit should be prepared for the State Society meeting in May on geographic distribution of industrial hazards in Connecticut.
- (3) There should be an informal group within the State Society of doctors interested in industrial medicine, a forum at the annual meeting in May.
- (4) Some part of the program of the Clinical Congress in September should be devoted to industrial hygiene.

Suggestions 2 and 4 have been acted upon.

At the Society's meeting this year there will be an elaborate exhibit on industrial hygiene prepared by Dr. Gray and his associates with the cooperation of the Committee. Doctors Gray, Linde and Barker and the Chairman of the Committee met at the Society's office on Jan-

uary 17, 1939, to discuss this exhibit. It seemed desirable, however, to modify the original suggestion that the exhibit show the geographic distribution of industrial hazards.

The exhibit will attempt to depict the importance of industrial hygiene in Connecticut by means of a chart showing the number of individuals employed in hazardous industries in the State by counties. Detailed information will be given concerning the major industrial poisons encountered, such as solvents, gases, metals and dusts, and this portrayal will be illustrated by charts, photographs, x-rays and pathological specimens. The importance of properly diagnosing and of reporting occupational diseases will be emphasized.

On the program of the Clinical Congress in September there will be a talk on industrial poisons, by Dr. George H. Gehrmann, Medical Director of the du Pont organization, the discussion following the talk to be led by Dr. Leonard Greenburg, Executive Director of the Division of Industrial Hygiene of the New York State Department of Labor, by Dr. Yandell Henderson, Yale physiologist, and by Dr. Albert S. Gray.

The Committee has cooperated closely with the parent Council on Industrial Health of the American Medical Association. A copy of the mimeographed report of the first meeting was sent to Dr. Carl M. Peterson, Secretary of the Council, who wrote the Chairman under date of January 3, 1939, as follows:

"I have received your letter and enclosure which I shall read at the meeting of the Council on Industrial Health which takes place here in Chicago on Wednesday, January 11.

"I want to present it to the membership of the Council as indicative of the possibilities which lie in a close relationship between the Council and the state committees. I am sure there will be a great deal of favorable comment which I will communicate to you subsequently."

As a result of this meeting of the Council on Industrial Health in Chicago, it was decided to organize a sub-committee on state organizations and to publish regularly an Industrial Health Bulletin, the first copy of which was issued on April 29, 1939, and sent to all members of the Connecticut Committee.

Dr. Peterson credits the Connecticut Committee with furnishing "very effective ammunition" in bringing this situation about in the following letter to the Chairman, dated January 18, 1939:

"You will be interested to know that on the basis of presentations made at the recent meeting of the Council on Industrial Health, it was decided to organize a sub-committee on state organizations whose purpose will be to integrate the activities of the Council on Industrial Health with the committees on industrial health in the state associations.

"This, of course, is to be interpreted as an acknowledgment of the very considerable services that can be rendered by the state agencies and the desirability for establishing some system of regular communication. I believe that a bulletin will probably be considered as the most useful machinery in which the experiences and activities of the state committees may be recorded together with pertinent information and decisions of the Council.



"Many thanks to you for supplying me with very effective ammunition to bring this situation about."

The Committee has endeavored to be of service whenever the occasion has arisen, as witness a request from Dr. William H. Weidman of Uncas-on-Thames, the Norwich State Tuberculosis Sanatorium, for information concerning industrial hazards in the Bon Ami and porcelain industries in order to evaluate the etiology of a patient's pulmonary fibrosis complicated by an atypical anemia. Under date of February 8, 1939, Dr. Weidman writes the Chairman as follows:

"I greatly appreciate the service which you have rendered me and have shown the letters to Dr. Campbell (the Sanatorium's superintendent)."

The Committee has been asked to cooperate with a newly organized Committee on Mental Hygiene in Industry, in which Dr. C. E. A. Winslow, Professor of Public Health at Yale University, is very much interested. The Committee on Mental Hygiene has its next meeting in Hartford, June 5, and it is expected that a member of the Committee will be present.

The Committee has received copies of a number of bills which have appeared before the General Assembly, as, for example, Senate Bill #150, "An Act Concerning Burden of Proof in Actions Concerning Occupational Diseases;" Senate Bill, #319, "An Act Concerning Workmen's Compensation" and Senate Bill #320, "An Act to Aid Claimants for Workmen's Compensation," but no concrete action was taken concerning these bills. The Committee needs to become better organized for study of, and action upon, legislative problems.

A number of bulletins, monographs and reprints have been obtained, which will form a nucleus of a library on industrial hygiene. A list of the publications is attached.

Respectfully submitted,  
CLIFFORD KUH, M.D.

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#### REPORT OF COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations held one meeting during the past year, at which time a general discussion was held with regard to what the committee should undertake. It was the consensus of opinion that we should not prepare copy for newspaper releases.

Dr. M. J. Lawler of Waterbury spoke of the Public Health forum conducted six to eight times a year by the Waterbury Medical Society at which a speaker of note talks on a medical or health subject followed by medical and lay discussion. The attendance varies from one hundred and fifty to over four hundred.

It seemed to the committee that such forums conducted by various local societies throughout the state might be the best means of establishing and maintaining very satisfactory public relations.

Very truly yours  
STUART H. BOWMAN, M.D.

#### REPORT OF PROGRAM COMMITTEE

Mr. President, and Gentlemen of the House of Delegates:

Your Program Committee has endeavored to arrange a program for the annual meeting that would particularly appeal to the men in general practice and to put into the time available as much information as we could.

An innovation will be noticed in that the papers are by members of our Society, while the summing up and discussions are by well known guest speakers from various teaching institutions. We want to express our appreciation to Doctors McClure, Allen, Lanman, Keefer and Fraser for their kind cooperation.

We trust that the material and arrangement will meet with your approval.

Very truly yours,  
D. C. PATTERSON, Chairman

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#### REPORT OF AUDITORS

The Auditors have carefully examined the report of Hadfield, Rothwell, Soule and Coates (Certified Public Accountants) with the Treasurer and have checked all funds in the hands of the Treasurer and find them correct.

CHARLES T. LAMOURE, M.D.  
H. GILDERSLEEVE JARVIS, M.D.

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#### REPORT OF COMMITTEE ON PERMANENT FUNDS

The Committee on Permanent Funds have checked the securities with the Treasurer and find them correct.

CHARLES T. LAMOURE, M.D.  
H. GILDERSLEEVE JARVIS, M.D.  
JAMES R. MILLER, M.D.

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#### WEDNESDAY AFTERNOON SESSION May 24, 1939

The meeting convened at 2:20 o'clock in the building of the New Haven Medical Association, President Campbell presiding.

The first order of business was a motion made by Dr. T. P. Murdock and seconded by Dr. J. D. Gold that the Secretary be instructed to send the greetings of the House of Delegates to Dr. Ralph E. McDonnell who was seriously ill at his home. The motion was passed.

After the roll call by the Secretary the business of the morning was continued. The Treasurer's report (printed on Page 193, issue of April, 1939) was then read by Dr. J. R. Miller and accepted.

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#### REPORT OF THE COMMITTEE ON NATIONAL LEGISLATION

Mr. President, Members of the House of Delegates:

The Committee feels that the one important piece of national legislation which merits consideration is the so-called Wagner Bill (S.1620), which is described in the preamble as a bill "to provide for the general welfare by enabling the several States to make more adequate provision for public health, prevention and control of disease, maternal and child health services, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance, and training of personnel;

to amend the Social Security Act; and for other purposes." The general principle of the bill is that of Grants in Aid, i.e., the Federal Government supplies funds for the purposes of the act only when the states also furnish funds.

In general, this bill is based upon the recommendations which were presented to the National Health Conference last year by the Technical Committee and which were discussed by the House of Delegates of the American Medical Association at its special meeting in Chicago. There are one or two slight differences in the Wagner Bill as compared with the proposals of the Technical Committee, the most important of which is that in the bill there is no differentiation between the program of care for the needy and that for the general medical care of the lower income group.

The bill is divided into several sections which cover the following subjects: (1) Grants to states for maternal and child welfare. (2) Special health work and investigations (3) Grants to states for hospitals and health centers. (4) Grants to states for medical care. (5) Grants to states for temporary disability compensation. The Committee will comment on these activities briefly, except the last, which has little bearing upon medical practice except that it will be necessary, of course for members of the medical profession to pass upon the question of disability in individual cases.

The general plan which the bill proposes for administering all of the grants is based upon identical principles. In every instance the National Government will furnish money for the different purposes stated only to states which already have in existence organized departments which govern each of the activities proposed and only under certain conditions of administration. The bill defines the way in which allotments are to be made to the states by the United States government, the chief principles governing allotment to be population, local needs and special problems. State programs must be approved by the head of the government department to whom particular programs are assigned, such as the Children's Bureau, the Public Health Service, or the Social Security Board. The law requires that the State methods of administration must be approved by the appointed federal agency, that an advisory council or councils composed of members of the profession and others with special knowledge must be formed by the States receiving aid in connection with each plan, that State Agencies must furnish such information as the federal authorities require, that appointment to the various State Agencies must be under a merit system, and that State Agencies shall have authority to make and publish such rules and regulations as are necessary. In the case of each of the activities, the department of the federal government responsible has the right to inspect and to withhold appropriations in case the state agency is not carrying out the purpose of a plan according to the regulations of the federal agency.

In the case of each plan mentioned, the federal government has appropriated sums of money increasing in amount from the fiscal year ending June 30, 1940, to the fiscal year ending June 30, 1942. During this period the sums appropriated are specified; after this period it is simply stated that a sum sufficient for the purposes of each plan is to be appropriated annually. The bill specifically authorizes the expenditure, for the various plans which it proposes,

of a sum of 74 million dollars in 1940 which increases to 189 million in 1942. It is obvious that this sum will have to be raised by taxation and that unless a reduction is made in the federal budget it must be raised by taxation additional to that already in existence.

Certain comments on the plans in general may be made. (1) In his introductory statement, Senator Wagner specifically states that the "bill does not establish a system of health insurance or require the states to do so. Under the bill the states will be free to develop plans of their own choosing, subject to necessary basic standards." However, Senator Wagner goes on to state that such plans may be limited to those on relief or include others more fortunately situated in the economic scale. It is also stated that the plans may be supported by contributions, by general revenue, or both. Senator Wagner also stated that state plans should be projected only after careful surveys of state needs had been made by duly constituted state agencies. However, nothing in the bill limits medical care to indigent persons and nothing in it prevents individual states from adopting some form of health insurance.

It seems to the Committee that one of the defects of this bill lies in the fact that under its terms authority is to be vested in three separate administrative departments: namely, the Children's Bureau, the Public Health Service, and the Social Security Board. While on the surface it appears as though the purposes of the different plans are so divergent that it would be logical for different departments to administer them, it would be likely, nevertheless, that there would be confusion and overlapping which could only be overcome by the creation of a general administrative board representing these different administrative agencies. In other words, it seems to us that if the plans proposed in this bill are to be put into effect, it is essential that all of the health activities of the federal government should be placed in the hands of a single agency, preferably a federal Department of Health, under an official of cabinet rank.

The bill proposes to erect and presumably equip a considerable number of hospitals, health centers, and diagnostic laboratories. There is no question, of course, that in some parts of the country there is a lack of all these facilities, but the creation of large number of new hospitals, new health centers, and new diagnostic laboratories would create some very difficult problems, the most serious of which would be the assembling of efficient staffs to man these institutions. It seems quite clear that if a large number of small hospitals were built in sections of the country which are now lacking in such facilities, it would be very difficult to guarantee that they could be efficiently staffed. It has been suggested that different types of hospitals might be created and that the smaller local hospitals might limit their work to emergencies and simple medical problems. In this era of good roads and mechanical transportation the more complex and difficult cases might be transferred to larger hospitals in the urban centers in order to obtain the advice of more experienced men in the medical cases and more expert surgery in surgical cases. It would seem to the Committee that the health centers and diagnostic machinery could well be combined with strategically located hospitals.

The House of Delegates last year emphasized another



point which we think is of the greatest importance, namely, that before any new hospitals are built in a given region, existing public hospitals should be utilized to the utmost under government subsidy and new institutions should only be built after a most careful survey of the local situation has been made.

There is some evidence that the sums of money which the government proposes to assign to hospitals will be inadequate to provide first class care. In the proposal of the Technical Committee, an expenditure of \$10 per capita for the care of each needy patient is suggested, whereas the experience of many non-profit hospitals would indicate that at least \$20 per capita is necessary.

It is to be noted that the bill contains no provision for the support of medical education and medical investigation except in the section dealing with special health work, which does provide some money for investigation in certain diseases. It would seem that if a large number of new hospitals are to be constructed, there should be some provision for federal aid to be used for training the physicians who are to administer them.

We may summarize the chief defects of the bill as follows:

(1) It is on the grants in aid principle so that whatever activities are carried on in this or in any other state under its provisions will be supervised by the federal government, which will have the power to dictate policy.

(2) That there is nothing in it that prevents states from adopting any plan of health insurance that they see fit to adopt.

(3) That it appropriates enormous sums of money which in all probability would have to be raised by new taxation.

Respectfully submitted,  
GEORGE BLUMER, M.D.



#### REPORT OF BUDGET COMMITTEE

Mr. President and Members of the House of Delegates:

In view of the contemplated enlargement of the scope of activities of the Society attendant upon the new Executive Secretary's position the Budget Committee felt itself called upon to present only a budget for the last six months of the year 1939, which is as follows:

Office of the Executive Secretary	\$3440.00
The Journal	2400.00
Legislative Committee Expense	300.00
Miscellaneous	500.00
Chairman of the Council	150.00
Council Expense	75.00
Tumor Committee	150.00
	<hr/>
	\$7015.00

The total increase suggested for the last six months as compared to the first six months of the year is \$765.00 which contemplates meeting additional rent for needed expansion for the Executive Secretary's office and which the Committee feels is well within the resources of the Society.

Respectfully submitted  
J. R. MILLER, M.D.,  
for the Committee

Dr. J. D. Gold, Chairman of the Council, then submitted the names of the officers and committees for the year 1939-1940. These nominations were accepted as read.

The Council recommended to the House of Delegates the approval of the budget for the six months period, July 1, 1939 to December 31, 1939, as recommended by the Budget Committee. Recommendation adopted.

The Council recommended that commencing with January 1, 1940 the Society employ a full time Executive Secretary and that the annual dues for the year 1940 be \$15 per member. Recommendation adopted without discussion.

The council recommended that the invitation received from the Hartford County Medical Association to have the 1940 Annual Meeting of the Society in Hartford be accepted. The date of the meeting to be determined by the Council. Recommendation adopted without discussion.

The Council recommended that the invitation received from the Middlesex County Medical Association to hold the 150th Annual Meeting of the Society in Middletown where the first meeting of the Society was held be accepted. Recommendation adopted.

The Council recommended that the petition received from a number of members of the Society for the formation of a section on physical therapy be approved and the organization of such section be authorized. Recommendation adopted without discussion.

The Council recommended that the request of the Connecticut Hospital Association to use the Journal of the Connecticut State Medical Society as the official publication of the Connecticut Hospital Association be approved and that the Council be empowered to complete financial arrangements with the Connecticut Hospital Association for this purpose. Recommendation adopted.

The Council recommended the adoption of the following amendments to the By-laws:

"Time for Election of Officers"

"Delete from Chapter V, Section 4, the sentence: 'The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the last day of the General Session'. The effect of this amendment is to permit the election of officers at any time during the annual meeting." After considerable discussion and the offering of an amendment which was lost therecommendation of the Council was adopted.

Concerning the disbursement of the Society's Funds.

"Chapter VI, Section 4, Add in paragraph 1, 'except provided,' so the paragraph will read:

"Section 4. The Treasurer shall give bond in the sum of five thousand dollars, the manner of bonding to be left to the Council. 'Except as otherwise provided,' he shall demand and receive all funds due the Society etc."

"The section is further amended by the addition of the following: 'The Treasurer is authorized to advance periodically to the Executive and to the Scientific Secretary and Editor of the Journal prorated portions of the funds allocated to the offices of the Executive Secretary and the Journal for the operation of the offices of the Executive Secretary and the Jour-

nal as provided in the approved budget. The Executive Secretary and the Editor of the Journal are authorized to make payments of necessary expenses for the activities of those offices from such prorated portions of the budgeted amounts received from the Treasurer, and the Executive Secretary and the Editor of the Journal shall render an accounting of such expenditures to the Treasurer from time to time as he may request, and a report of such expenditures for the year shall be consolidated with the report of the Treasurer presented to the House of Delegates at the Annual Meeting each year." Recommendation adopted.

Concerning a Committee on the Clinical Congress  
 "Chapter VII, Section 1. Add after a Committee on Public Relations 'a Committee on the Clinical Congress.' Add a new Section 8. 'The Council shall nominate to the House of Delegates each year a Committee on the Clinical Congress and designate a Chairman, a Secretary and a Treasurer of the Committee. The function of the Committee shall be the arrangement and direction of the annual Clinical Congress of the Society and such other activities in post graduate instruction as may from time to time appear desirable to the Committee. The Chairman, the Secretary and the Treasurer shall be the trustees of the funds of the Clinical Congress and this Committee, through its Treasurer, shall receive income from registration fees of the Congress and other sources as may attend the administration of the Congress, and pay therefrom all necessary expenses. This fund shall be known as the Clinical Congress Fund and shall be retained in the hands of the Treasurer of the Clinical Congress, shall be audited by the Society's auditors and a report of the transactions of the fund for the fiscal year shall be rendered by the Treasurer of the Society to the House of Delegates each year at its annual meeting. The Treasurer of the Clinical Congress shall be bonded by a corporate surety in the sum of five thousand dollars, the premium on such bond to be paid from the Clinical Congress Fund.'" Recommendation adopted.

Concerning Committee on Industrial Health.  
 "Chapter VII, Section 1. Addition to Section of a Committee on Industrial Health.' Addition of a new Section 9. 'The Council shall nominate to the House of Delegates each year one member from each County Association to be a member of the Committee on Industrial Health and designate the Chairman of this Committee. The function of the Committee on Industrial Health shall be to inquire into the health hazards of industry with the view of making information on the subject available to members of the Society and improving the health and hygiene of persons employed in industry.'" Recommendation adopted.

Concerning time or presenting nominations to the House of Delegates.

Chapter VII, Section 3. "By the substitution of 'during the first session' for 'the first day of,' so that the section will read: 'The Council shall serve as the nominating committee of the Society and report as

such to the House of Delegates during the first session of the annual meeting.'" Recommendation adopted.

Concerning deposit of Society's Funds

"Chapter IX, Section 1. Add new first paragraph. 'The fiscal year of the Society shall terminate on December 31st of each year.' Add new final paragraph. 'All funds of the Society by whoever held shall be deposited promptly upon receipt in a state or national bank located in the State of Connecticut.'" Recommendation adopted.

Concerning prorating of County Association members dues.

"Chapter IX, Section 1. By the addition of a new clause to the first sentence. 'Except that members elected to the County Associations at the semi-annual meetings in October will be assessed one-half of the annual dues.' So that the chapter shall read: 'Funds shall be raised by an equal per capita assessment on each component association except that members elected to the County Associations at the semi-annual meetings in October will be assessed one-half of the annual dues for the year of their election. The amount of the annual assessment per member shall be fixed by the House of Delegates.'" "

Concerning Fiscal Year of the Society

"Chapter XI, Section 10. The dues of the Society shall be due and payable on January 1st of each year and the fiscal year of the Society shall terminate on December 31st of each year. Amend by elimination of 'and the fiscal year of the Society shall terminate on December 31st of each year.'" Recommendation adopted.

At the morning session there was a call for a decision on the attitude toward osteopaths. Dr. Creighton Barker presented the following motion:

"That the President of the Society be directed to appoint a committee of three to inquire into the subject of the osteopathic law, to establish a policy for this Society in connection therewith, and to report to the House of Delegates at its annual meeting in 1940." After considerable discussion the motion was carried.

Dr. Barker then presented the following motion:

"That the Council be authorized to prepare an amendment and further the passage of such an amendment to the effect that members in good standing for forty years be exempted from the further payment of dues to the Society." After explanation by the Secretary the motion was carried.

Dr. Barker then presented another motion as follows:

"That the Council be directed to inquire into the policy of the state dues being collected by the state Treasurer." After some discussion this motion was carried.

The Hartford County Medical Association presented the following resolution:

"Inasmuch as the O.C. Smith fund is of insufficient size to care for any appreciable number of indigent members should the annual dues be increased, it would seem expedient and wise to make provision in



some other manner for the payment of dues of such indigent members of the State Society. It is therefore moved that this matter be referred to the Council in order that provision may be made in the by-laws of the Society for such members." Considerable discussion followed on the O. C. Smith fund. The motion was carried.

Dr. Barker presented the following motion:

"That the Program Committee of the Society be instructed by the House to arrange a mid-winter meeting of the Society at an appropriate date." Motion carried.

A motion was made by Dr. Barker that the President of the Society appoint a committee of five to inquire into the subject of prepaid medical service with instructions to report to the House of Delegates at its annual meeting in 1940. Dr. Barker said that there has been considerable interest in this type of activity in other states and because we have been interested in it more than a year we should know more about the experiences of people and societies elsewhere. The motion was carried.

Dr. Barker then moved that the Committee on Public Relations of the Society be instructed to embark upon a proper and dignified program of furthering public information concerning the Connecticut State Medical Society. This motion was passed without discussion.

Discussion was then opened regarding action on the Wagner Bill (S.B.1620). In this discussion it was very evident that many of the delegates were not sufficiently familiar with the bill to discuss it intelligently. A motion was made by the Editor of the Journal that the House go on record as opposed to the Wagner Bill in its present form. This was amended by the Executive Secretary to the effect that the President of the Society appoint a committee of three members from the House to draft a resolution expressing disapproval of the bill, this resolution to be presented to the House of Delegates at its meeting to be held two days later. Dr. Louis H. Nahum objected to having the entire bill thrown out as undesirable. The treasurer called attention to the fact that we should not commit ourselves as an entirely reactionary state organization, acting entirely upon an emotional basis. After extensive discussion by other members of the House the original motion was lost and a motion carried to appoint a committee to report on the bill at the next session of the House two days later.

Dr. Miller then moved to proceed to the election of officers. This motion was carried. Upon a duly made motion one ballot was cast by the Executive Secretary for the slate of officers as nominated that same morning.

After a brief recess the President announced the following committee to bring in a report two days later on

the Wagner Act:—Arthur B. Landry, W. Bradford Walker and George Blumer.

Meeting adjourned at 3:55 p.m.

#### FRIDAY MORNING SESSION, May 26, 1939

The House of Delegates convened at 9:35 o'clock at the Hotel Taft, President Campbell presiding. The roll was called by the Secretary.

The following were then presented by the committee appointed to consider the Wagner Act:—

"Whereas the *purposes* of the National Health Bill of 1939, namely the more adequate provision for medical health, the prevention and control of disease, maternal and child welfare, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance and training of personnel, should have the approval of The Connecticut State Medical Society, and

"Whereas the *methods* proposed for bringing these purposes about are open to objection for the following reasons:

"1. The control of the complete program" — the Committee asked to delete the next four words "proposed for the bill" — "by several independent federal agencies, whereas the medical profession through the American Medical Association has favored a single federal department of health under an officer of cabinet rank.

"2. The complete control of cooperating state agencies by the federal agencies which are given authority to disapprove state plans and to withhold appropriations even when plans are already in operation under federal approval.

"3. The lack of recognition of the principles contained in the resolutions of the House of Delegates of the American Medical Association passed in 1938 after careful study of the many purposes covered by the bill.

"4. The lack of recognition of the necessity for adequate housing and nutrition in the prevention of disease.

"5. The absence of any distinction between the indigent and those with adequate means in the administration of the proposals.

"6. The failure to safeguard the continued existence of the general practitioner and the basis patient-physician relationship.

"Therefore be it resolved by the House of Delegates of The Connecticut State Medical Society assembled this 26th day of May, 1939,

"That we go on record as favoring the extension of medical service to the needy and indigent and the expansion of preventive medicine and public health where need can be shown, but by the development of a mechanism for this purpose which is within the philosophy of the American form of government and without damage to the quality of medical service.

"Be it further resolved that we oppose the passage of the Wagner bill in its present form and we favor the com-

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plete autonomy of individual states in the preparation and execution of plans to provide for such purposes as are covered in this bill. We believe that the federal government should restrict its activities to surveys, recommendations and the provision of subsidies for health activities when the need is demonstrated to the satisfaction of" — and then we can delete the next word, "the" — "conferees representing a state and the federal agencies.

"Submitted,  
ARTHUR B. LANDRY  
GEORGE BLUMER  
W. BRADFORD WALKER"

In the discussion of the above resolutions Dr. Nahum objected to reason No. 3 since the principles there referred to were not listed and many were not familiar with them. Dr. Blumer explained the background of these resolutions. Dr. Barker moved the adoption of the resolutions. The motion was carried.

Dr. A. S. Hewitt moved that the Secretary be instructed to send a copy of these resolutions with the action of the House of Delegates to each of our Senators and Representatives in Washington. This motion was carried.

Dr. Cole B. Gibson then moved that the House of Delegates direct the Council to proceed upon the employment of a full time Secretary to carry out the mandates of a resolution presented before the House at its first session three days previously. This motion was passed without discussion.

Adjournment then followed at 9:50 o'clock.

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## MEDICAL AIR RAID PREPARATIONS IN ENGLAND

(Concluded from Page 504)

These lights are manned constantly in two zones. The outer zone about a city having a range of 25 miles, selects approaching planes and the inner zone of lights spots the planes for anti-aircraft gunners. Balloon barrages will be used in London to keep the invading planes at a high altitude.

What becomes of private medical practice? Legislation will soon be passed by Parliament to take care of indemnifying the private citizen against loss of property. No indemnification, however, will be forth coming for the physician who loses his private practice. As long as the emergency exists, people will be dispersed and private practices will be non-existing. The physicians will probably never be able again to collect their former practices and accordingly will be dependent upon governmental office for their livelihood. But people will have become accustomed to governmental protection. Their medical care will be free. A new economy in medicine will come to exist, which is already causing misgivings in the minds of medical leaders in England.

## • OBITUARIES •

WILLIAM A. DOWER, M.D.

1905-1939

His medical confreres, his many friends and his numerous patients were stunned at the news of the untimely death on May 13, 1939, of Doctor William A. Dower of Windsor. He was stricken ill in his office while attending a patient the evening of May 12, 1939.

Doctor Dower was born in East Hampton, Mass., on April 20, 1905. After attending the Georgetown School of Foreign Service for a time, he matriculated at Trinity College in Hartford. In 1933 he obtained his medical degree from Tufts Medical School. After serving one internship at St. Margaret's Hospital in Dorchester, Mass., he was occupied for one year as an interne at St. Francis Hospital, Hartford.

After completing this internship, he engaged in practice in Windsor where he enjoyed a large clientele to whom he was most faithful. Not having been for some time very strong physically, he was advised against practicing in such a small community, entailing, as it does on the whole, harder and more time-consuming work with the same accomplishments as city practice. However, once having chosen his place in life, he devoted himself earnestly to his family and his patients, so much so that his labors were a strain upon his health and undoubtedly precipitated his early demise.

His mother, wife and two small children survive.

Benedict B. Landry, M.D.

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PERCY GREENOUGH DRAKE

1876-1939

Percy Greenough Drake was born on a farm in Rye, Rockingham County, New Hampshire on Christmas Day, 1876. He was the youngest of two boys and two girls born to Charles A. Drake and Helen Weeks Drake and the last of these to die. His younger sister married Dr. Charles A. Patterson, for many years a popular general practitioner of Rye. He attended the public schools of Portsmouth, at which high school he prepared for Dartmouth College. From the



latter he graduated with the degree Bachelor of Science in 1899, and was a member of Theta Delta Chi fraternity. He took his degree Doctor of Medicine from Harvard University in 1904 and during his medical school days he worked as an apprentice in a drug store. After medical graduation he spent considerable time at the Massachusetts General Hospital.

In July 1907 he joined the medical corps of the United States Army. His first station was Fort Jay, Governor's Island, New York. Then followed Madison Barracks, Sacketts Harbor, New York; Fort Hancock, Sandy Hook, New Jersey; and Fort Ethan Allen, Vermont. He sailed for the Philippine Islands on December 5, 1909 and was stationed at Fort San Pedro one year as surgeon of the Post. Another eleven months he was attached to the Philippine Scouts as surgeon, going to Cebu, Northern Mindanao, Manila and other places. Four months were spent at Camp James Connell, Samar. In the Philippines he had considerable experience caring for lepers. Dr. Drake returned from the Philippines by the way of China and Japan, to be stationed at Fort McKinley, Portland, Maine from March 1912 to January 1914. General Hugh Drum, recently assigned to King George and Queen Elizabeth of Great Britain on their visit to the United States, was an army associate and friend of Dr. Drake.

His army service completed, he began his long period of insurance work which ended only with his death. His first position was traveling Medical Inspector in Oklahoma with the Equitable Life Assurance Society of New York. Next he was Assistant Medical Director of the Guardian Life of America. In 1920 he came to the Travelers Insurance Company as Assistant Medical Director, which position he held to his death.

On October 22, 1914 Dr. Drake married Rita Helen Taylor of Baltimore, Maryland at St. Gregory's Church in that city. The interests of these two were so close that a most happy, devoted life followed. No children came of this union.

While in the army, Dr. Drake enjoyed tennis, horseback riding, sailing and dancing. In later life walking was greatly enjoyed by Dr. Drake and Mrs. Drake.

Each year Dr. and Mrs. Drake enjoyed profitable vacations by trips to the West Indies,

and Florida, Canada and the Great Lakes. Dr. Drake loved people and had a true gift of kindly, clean humor. He was most loyal to New Hampshire, where he was born and reared, Dartmouth College, his beloved Alma Mater, and his classmates of '99 at Dartmouth. Hartford, his last home for 19 years, was proud of him and he of Hartford. Of exemplary habits, his quiet, gentle, genuine character endeared him to all his associates at the Travelers Insurance Company. Primarily a home man, he had belonged to the University Club of Hartford, the Hartford Medical Society, Hartford County Medical Association, the Connecticut State Medical Association, the American Medical Association, and the Association of Life Insurance Medical Directors of America.

Brought up as a Congregationalist, he joined the Catholic Church in Boston, Massachusetts just before his marriage and remained a devout Catholic to the end. He was a member of St. Thomas Church, West Hartford, Connecticut.

Suffering no serious illness until he reached around sixty years, from then on his life was hampered increasingly by the inroads of malignant hypertension and arterial degeneration. Before his death, for many months he was confined, totally helpless and speechless, to his bed.

Consideration for others, generosity, gentleness, humility, patience, honesty, self-sacrifice, and loyalty were some of the conspicuous characteristics of this Christian gentleman and friend. To know Percy was to love him.

In June this year a memorial service was held by his classmates celebrating their Fortieth Reunion at Dartmouth College.

He died May 22, 1939 after a lingering illness borne with great fortitude and courage. He lies buried in the Cathedral Cemetery, Baltimore, Maryland. To Mrs. Drake, his life long companion and help-mate, goes our sympathy.

John A. Wentworth, M.D.



#### EYE, EAR, NOSE AND THROAT SECTION ELECTS OFFICERS

Officers for 1939-1940 of the Eye, Ear, Nose and Throat Section of the Connecticut State Medical Society are as follows:

Chairman . . . . . Shirley H. Baron, New London  
Vice Chairman . . . . . W. E. McClellan, Hartford  
Sec.-Treas. . . . . S. J. Silverberg, New Haven

## • Quarto Notes •

### LIFE AND LETTERS OF DR. WILLIAM BEAUMONT.

by

Jesse S. Myer, A.B. M.D.

Late Associate in Medicine in Washington  
University, St. Louis

327 pages	new printing	\$5.00
St. Louis	C. V. Mosby Co.	1939

This book was originally published in 1912 on the hundredth anniversary of William Beaumont's entry into the practice of medicine. The value of Dr. Beaumont's experiments on the physiology of the stomach have long been appreciated. During the interval since the first printing of this book there has been an increasing interest in Beaumont the physician. In particular in Connecticut, Dr. Beaumont's native state, do we find a growing appreciation of the man and of his epoch making contribution to medical science.

The volume by Dr. Myer is handsomely printed with a wealth of illustrations, many of these of original manuscripts written by or to Dr. Beaumont. The author has unearthed many hidden treasures of information and all anecdotes presented have been first carefully verified.

As one reads this volume one is impressed with the difficulties encountered by the frontier Army Surgeon because of slow transportation and lack of facilities for extensive laboratory research in this country. One is also impressed with the perseverance and indomitable courage of the man, fearless in the face of criticism because convinced of his own integrity. The picture of life at Mackinac and at Sacketts Harbor in the early 19th century is revealed by excerpts from Beaumont's diary. Transportation by the canal system of the Great Lakes and by Stage in New England is vividly portrayed. Beaumont's correspondence with Professor Dunglison of University of Virginia and with Surgeon General Lovell should be of considerable interest to the reader. The impressions made by Congress and expressed by Beaumont and some of his friends remind one a little of legislative accomplishments at Washington today.

It would be an oversight to omit mention of Dr. Beaumont's experiments on his patient Alexis St. Martin. They are carefully described in this volume and the observations and deductions made by the Army Surgeon carefully presented in detail. Perhaps no better tribute could be paid the author of this attractive volume than to express the desire one must feel as the final pages are reached to read in detail a copy of Dr. Beaumont's experiments and deductions as set forth by this physician one hundred years ago. The book is commended to layman and physician alike for its completeness, attractiveness and sustaining interest.

### PRACTICE OF ALLERGY

by

Warren T. Vaughan, M.D.

1030 pages		\$1.50
St. Louis	C. V. Mosby Co.	1939

Dr. Vaughan has presented in this monograph of over 1000 pages of text and 30 of bibliography a most excellent and complete consideration of every phase of the allergic problem. Out of the welter of confusion in allergic nomenclature, experimental data and immunologic theories, he carefully and skillfully guides the reader to a reasonable though admittedly inadequate concept of the allergic phenomenon. Admitting many experimental contradictions and a woeful lack of understanding of the fundamentals of human sensitivity, he holds that Ehrlich's side-chain theory, together with Lewis' H-substance hypothesis, offers the best present day explanation of the known facts about allergy. Thus he adheres to the view enunciated by his father Dr. Victor C. Vaughan, that the underlying mechanisms of allergy and immunity are the same or closely related — a viewpoint which has been stoutly challenged by Rich.

After an adequate discussion of the theoretical and experimental aspects, he devotes the major portion of his book to detailed and practical instructions for the diagnosis and care of the allergic patient. All phases of pollen, dust, food, contact and physical allergy are considered. He emphasizes the fact that human sensitivity is so prevalent that it not only provides its own category of morbid states, but modifies markedly the clinical appearance and course of many non-allergic diseases. Thus in his introduction he alters Fournier's dictum, "To know syphilis is to know medicine," by saying, "To know allergy one must know medicine." Hence this monograph is not written for the allergist only but rather for the practitioner of internal medicine, to whom it should prove a vademecum for some time to come.

A. R. Felty.

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### A.M.A. COUNCIL ON PHARMACY AND CHEMISTRY REPORTS FOR 1938

123 pages

Chicago American Medical Association 1939

This volume is exceedingly valuable as a reference book for any and all practitioners of medicine. Within its covers may be found the reports by the Council on Pharmacy and Chemistry on such products as allantoin, ergonovine, liver meal and sulfapyradine. It contains the reports of the Council previously published in the Journal of the A.M.A., along with such editorial comments as have accompanied them. In addition, the volume contains reports of the Council which, because of their lesser importance, were not published in the Journal of the A.M.A.



**DISEASES OF THE NOSE AND THROAT**

by

**Charles J. Imperatori, M.D., F.A.C.S.**

and

**Herman J. Burnam, M.D., F.A.C.S.**PP. 726      480 illustrations      second edition revised  
Philadelphia, Pa.      J. B. Lippincott Co.      1939

The book is attractively printed on good paper presenting its material in a concise outline form. In spite of this popular plan, the most commonly encountered diseases are fully described, while the less common conditions are briefly mentioned. It follows a uniform pattern; for instance, in the discussion of a disease the following are considered: symptoms, diagnosis, treatment, pathology, prognosis and then etiology. The development, the anatomy and physiology of each anatomical member are discussed to the point under the respective sections on the nose, nasopharynx, mouth and throat, sinuses, larynx, bronchi and esophagus.

There are fifty-two chapters. The first three chapters are allotted to a detailed discussion on the examination of the patient. Chapters four to eight are given over to the nose which include a fairly good resumé of plastic repair of nasal deformities. Chapters nine and ten discuss the septum. Chapters eleven to twenty-one discuss the nasal accessory sinuses; chapters twenty-two to twenty-four, the nasopharynx; chapters twenty-five to thirty-four, the pharynx and mouth; chapters thirty-five to forty-one the larynx; chapters forty-four to forty-five, the esophagus; chapter forty-six, peroral endoscopy. The authors discuss in detail the endoscopic procedures including gastroscopy and duodenoscopy. Chapters forty-eight to forty-nine discuss ably and amply physical therapy and radiation. Chapter fifty, under allergic diseases, discusses hay-fever and asthma. In chapter fifty-one the general diseases as related to the nose and throat are briefly covered. Chapter fifty-two is allotted to laboratory aids in rhinolaryngology. There are four hundred and eighty illustrations which include a few microscopic photographs and anatomical drawings.

The book does not contain anything that is not already known, but it is up-to-date and the one who refers to it will find out easily what one wishes to know. It is a good practical text on rhinolaryngology.

N. Samponaro

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**NEW AND NON OFFICIAL  
REMEDIES, 1939**684 pages      \$1.50  
Chicago      American Medical Association      1939

To anyone who is familiar with previous editions of this volume little need be said. To those unfamiliar with its contents a hasty perusal will serve to convince of its value. It contains a list and description of those articles accepted by the Council on Pharmacy and Chemistry on January 1, 1939. Those articles omitted since the previous edition are listed in the preface, together with a list of those omitted as being off the market. The grouping together

of articles having similar composition or actions is continued in this edition and the statements covering the actions, uses, or dosage of many products have been revised. The statement of composition, of standard of purity, identity, or strength, or of physical qualities has been revised in the case of many products.

In addition to a general index and an index to distributors, this volume contains a biographical index to proprietary and unofficial articles not included in New and Non official Remedies.

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**SHORT STATURE AND HEIGHT  
INCREASE**

by

**C. J. Gerling.**159 pages      \$3.00  
New York      Harvest House      1939

This is a discussion of growth and height and possible means of augmenting them, evidently intended for the layman. The language is simple and clear. Opinions expressed are conservative and the efficacy of drugs and endocrine preparations at our disposal is not exaggerated.

The importance of optimum food and rest is emphasized. Detailed descriptions of effective exercises are included. Posture is discussed. Proper clothing is pictured and described and the addresses of special bootmakers are given. Fallacies in the claims of manufacturers of various sorts of apparatus advertised as height-increasing are pointed out.

There are a few minor criticisms. Fluency is lessened by constant unnecessary references to previous or succeeding chapters, and the final chapter, "Psychological Aids," is so naive in its praise of shortness that it will probably detract from the usefulness of the book as a whole, except for immature readers.

It is certainly a harmless book and will be reassuring and encouraging to small persons and to parents who wonder whether they are doing everything necessary for their small children.

S. A. Root

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## SPECIAL NOTICES

### AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

The American Congress on Obstetrics and Gynecology will hold its first session in Cleveland, September 11-15, 1939. The Congress is sponsored by the American Committee on Maternal Welfare, Inc., for the purpose of studying our present day problems on obstetrics and gynecology and their solution. The membership fee is \$5.00, which includes a year's membership in the American Committee on Maternal Welfare as well as registration in The American Congress on Obstetrics and Gynecology, Cleveland, Ohio, September 11-15, 1939.

Headquarters Office: The Annex, 650 Rush Street, Chicago,

Make checks payable to R. W. Holmes, Treasurer,  
Chairman State Committee:

Dr. Joseph H. Howard, Bridgeport.



### AMERICAN CONGRESS OF PHYSICAL THERAPY

The 18th annual scientific and clinical session of the American Congress of Physical Therapy will be held September 5, 6, 7, 8, 1939 at the Hotel Pennsylvania, New York City. Preceding these sessions the Congress will conduct an intensive instruction seminar in physical therapy for physicians and technicians — August 30, 31, September 1 and 2.

Physicians are urged to plan their vacation for these periods and bring their families to New York for the World's Fair. Ample time has been provided for during the convention to visit the fair and to enjoy the various activities of America's metropolis.

While the convention proper will have numerous special program features of scientific interest, the added attraction of the World's Fair should make it extremely worth while for every physician to come to New York and spend a most profitable vacation.

The instruction seminar should prove of unusual interest to physicians and technicians. The clinics which comprise half of the schedule make this course outstanding for its practical value. As in the past outstanding clinicians and teachers will participate. Registration is limited to 100 and is by application only. For information concerning seminar and preliminary program of convention proper, address American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

### EXAMINATIONS AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The American Board of Obstetrics and Gynecology announces that at the recent examinations held by the Board at St. Louis, Missouri, on May 13, 14, 15, and 16 two hundred and fifty-nine candidates were examined. Two hundred and twenty-eight candidates were successful in the examinations and were certified by the Board, twenty-nine candidates failed, and two examinations were not completed by the candidates.

At the annual meeting of the Board, held in St. Louis on May 12, 1939, it was found necessary, on account of increased administration expenses, to increase the application and examination fees. Effective immediately, these are to be as follows: Application fee \$15.00, payable upon submission of application for review by Board. Examination fee \$75.00, payable upon notification to candidate of acceptance of the application and assignment for examination. Neither fee is returnable. This increase does not apply to candidates whose applications were filed prior to May 12, 1939.

The next written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 6, 1940, at 2:00 P.M. The Board announces that it will hold only one Group B, Part I, examination this year prior to the final general examination (Part II), instead of two as in former years. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held in June 1940.

**Applications for admission to Group B, Part I, examinations must be on file in the Secretary's office not later than October 4, 1939.**

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting in Atlantic City, N.J., on June 8, 9, 10, and 11, 1940, immediately prior to the annual meeting of the American Medical Association in New York City.

Applications for admission to Group A, Part II examinations must be on file in the Secretary's office not later than March 15, 1940.

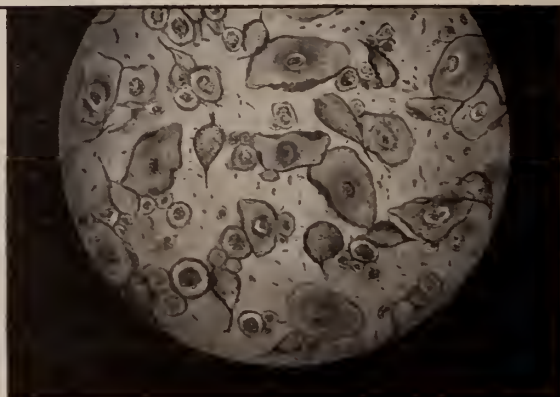
After January 1, 1942, there will be only one classification of candidates and all will be required to take the Part I examinations (written paper and case records) and the Part II examinations (pathological and oral).

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh<sup>6</sup>, Pennsylvania.



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## KENTUCKY'S HEALTH IN 1938

Kentucky had in 1938 the best year, from the standpoint of health, in its history. While the preliminary figures just made public by the Bureau of Vital Statistics will, no doubt, be somewhat changed by delayed certificates, the tabulations issued indicate with approximate accuracy the final results. At the time these tabulations were made, 28,636 death certificates had been recorded, with a rate of 9.5 per 1,000 population. This is the lowest death rate ever recorded in the State. Never before has this rate fallen below 10.0 per 1,000 population. In 1937, it was 10.6.

*Bull. Dept. Health of Ky., Apr. 1939.*



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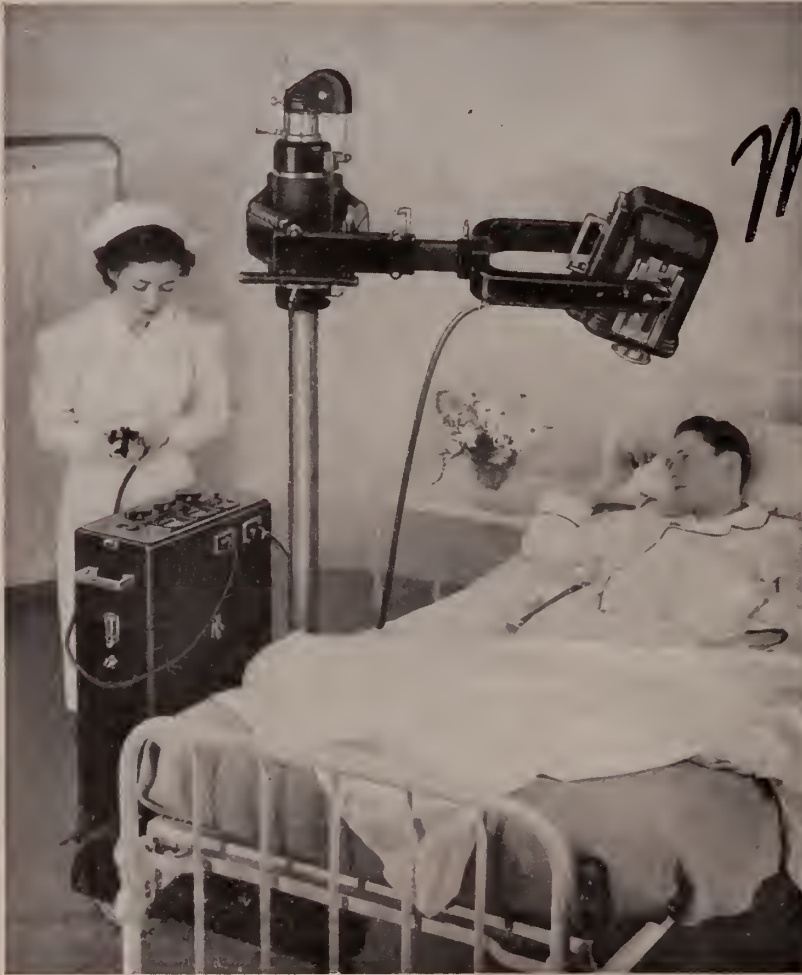


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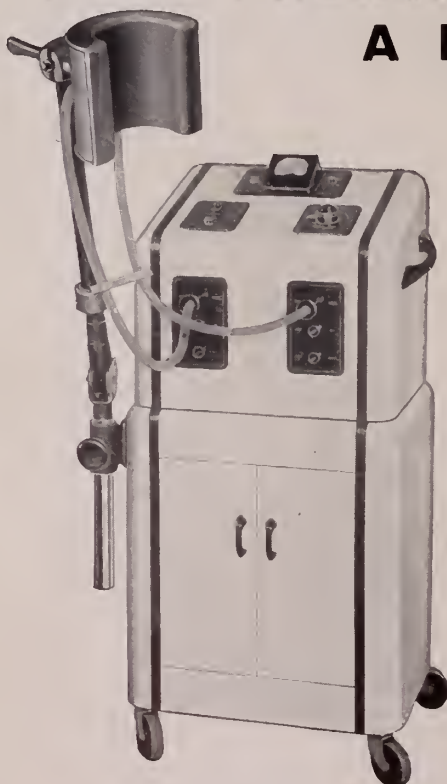
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# JOURNAL of The Connecticut State Medical Society

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THE CONNECTICUT STATE MEDICAL SOCIETY

Editor-in-Chief - STANLEY B. WELD, M.D.,  
54 Church Street, Hartford, Connecticut

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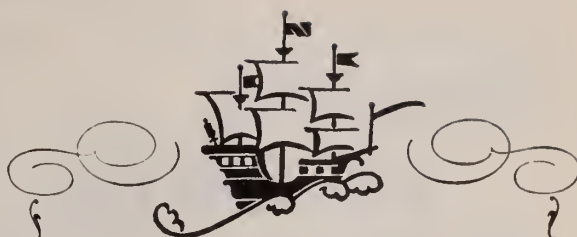
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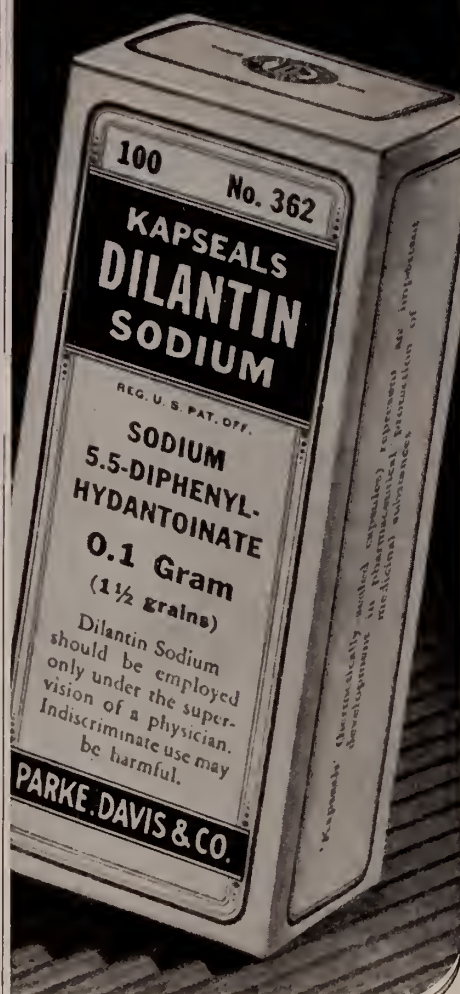


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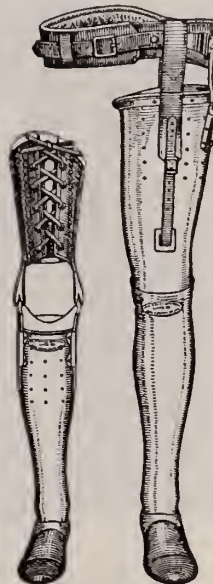
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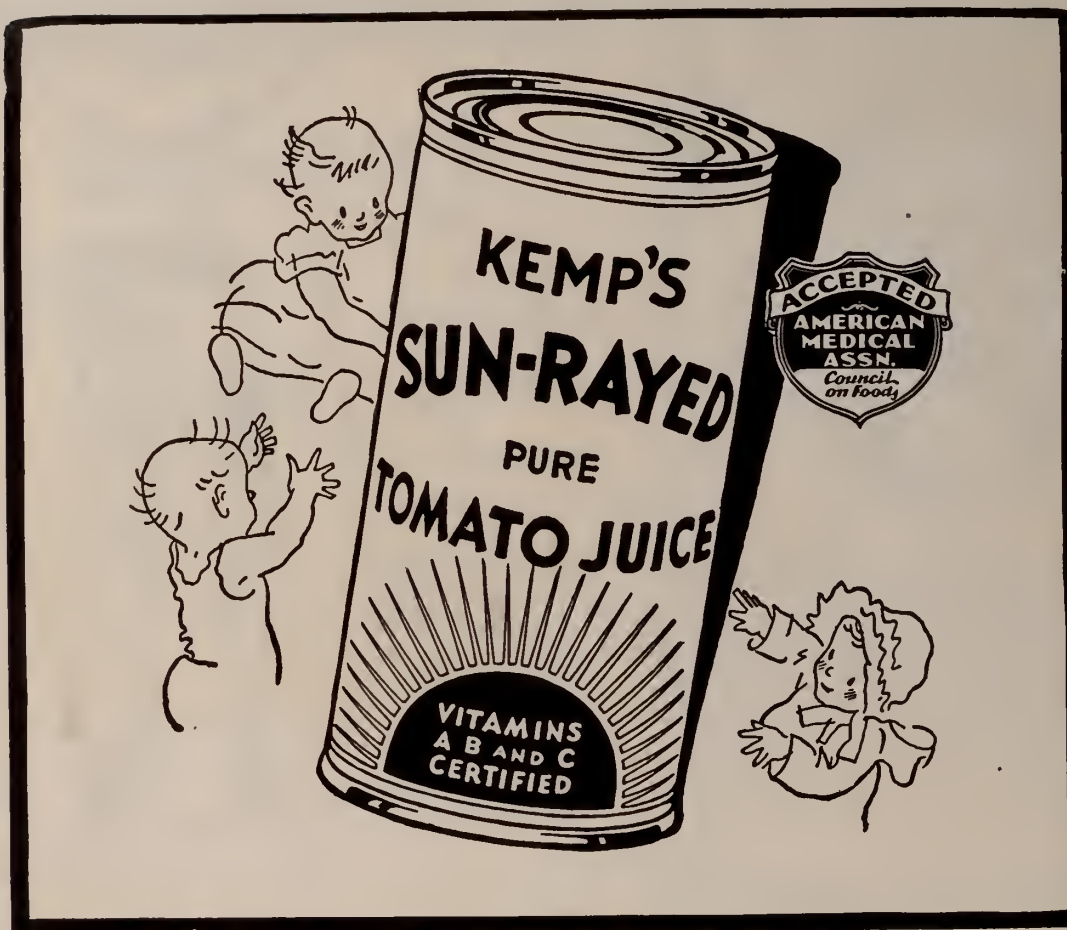
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# JOURNAL *of* The Connecticut State Medical Society

VOL. III.

OCTOBER, 1939

No. 10

## Valedictory\*

CREIGHTON BARKER, M.D.  
New Haven, Conn.

On April 27, 1922, this Association honored me by electing me its Clerk, and for exactly seventeen years to a day, I have served you as your Clerk, Vice President and President. It has been a unique and valuable experience. In more than 150 years of the Association's life no one has served continuously for so long a period, and I shall always look back upon it with pride and affection. It has contributed a great deal to my life, and I am grateful. To all of you with whom it has been my privilege to work as Officers and on Committees, I want to express my appreciation and thanks for your unselfish cooperation and thoughtful judgment that has contributed so much to the progress and prosperity of the Association. Many who gave me the most guidance and instruction are no longer here, the debt that I owe to Doctor Carmalt, John Lane and Frank Wheeler for clear thinking and honest help can never be repaid, and the fine pleasure that I had in intimate association with Walter Barber, Louis Gompertz and Harry Anderson is quite beyond value. My contribution in return for all this has been small but I have served with good intent. Today, five minutes ago, it came to a technical end, but I have no sadness, I am pleased to step aside and welcome my steadfast friend, Cole Gibson, as my successor. You have chosen well, he will wisely administer your affairs.

It may be that when the final scroll of history is unrolled, these seventeen years will span the greatest changes that medicine will record, the

closing of an old epoch and the opening of a new. The science of medicine has made great progress during those years in the vast field of chemistry in relation to disease, in the entirely new knowledge of the vitamin elements in diet; in a practically workable understanding of the functions of the endocrine glands; in the treatment of disorders of metabolism; in the almost uncanny results of research in specific chemotherapy and in the development of new skills in neuro and thoracic surgery. It has been a time of extraordinary achievement, new in concept, new in design; many ancient and inadequate methods have been discarded, and new ones sought and found. While all this has been going on in medical science, a part of medicine has remained static. It is a rather intangible part to which we have heretofore given little thought, and is not easy to define simply. Perhaps the "availability" of medicine is the best way to put it. The science and methods of medicine have gone ahead so fast that devices for the useful distribution of them have not kept pace. The reasons for this are numerous and complicated, partly economic, partly social and partly our own fault. And they are so closely interwoven that although they may be independent they are practically inseparable.

By a strange coincidence this Association was meeting in Waterbury on that fateful October day in 1929, when the security and commodity markets collapsed. Not many members were courageous enough to leave their broker's offices,

\*Address of the retiring President, New Haven County Medical Association, April 27th 1939.



and those who did come to the meeting were more interested in the Wall Street dispatches than in the program. At the time no one of us realized the far reaching influence the hectic happenings of that Thursday and the events that led up to them, would have on medical practice ten years hence, but surely the professional lives of us all have been affected by disrupted economics.

Jolted by economic catastrophe society has become disordered, political parties have new bases for alignment, labor has become increasingly powerful, capital enterprise has been looked upon with disfavor, and medicine has ceased to an independent priesthood, a law unto itself. Perhaps I draw too simple an analogy, when I see that the people are coming to look upon medical care as a public utility, like electric power, needed by everyone and necessarily available to meet that need. In all logic it is not an unreasonable point of view, but we have not been quite willing to accept it. We are reluctant to forsake some of our old traditions, and somewhat remiss in our efforts to mold public opinion. A rather one sided picture has been presented to the public, and the other phases of the problem will remain unexplained unless medicine itself undertakes the task. Changes in the distribution of medical care are going on, and I believe others are bound to come. This will inevitably lead, as it has already led, to increased interest in medical practice on the part of the people, and increased influence and authority over medical practice from Government, which is the people's agent.

If the best interests of our profession are to be served during these times of confusing change, medical associations such as ours can no longer remain quiescent laissez-faire organizations with their future behind them. Our problems are no longer wholly within ourselves. American medicine has reached the stage where it is playing a vital role in the nation's economy. We have a public and social responsibility that must be met, not to see those responsibilities reflects upon our

intelligence, to shrink them will surely bring us discredit.

No one is more reluctant than I to advocate that medicine go into public politics, but the fact is that public politics have come into medicine, and wisdom points that we should meet the situation fairly and with the honest strength that is surely ours to use.

There will be some among you who will feel that the views I have expressed in this brief valedictory are too pessimistic, you may call them radical. It is in my peaceful heart to agree with the most conservative of you, but alas! I cannot delude myself. The relatively calm order of medical practice that prevailed that fine autumn day seventeen years ago when I first became your Clerk, has gone, and no amount of pious hope or wishful thinking on your part or mine will bring it back. In the new scene are things that are neither familiar nor sentimental objects, but I am confident we are intelligent enough and ambitious enough to shape the new order for mutual good.

Connecticut is still the land of steady habits, and the best of these is the habit of slow and careful thought. This State is our home, for some a home by birth and inheritance, for others from distant lands a home of happy adoption; but in all of us is an integrity of character that makes us unselfishly willing to serve our fellow man, and a quality of mind capable of facing our problems and soundly and fearlessly arriving at their solution. This Association has opportunities for service that it must meet if medicine is to go on in the self reliant pride that is our honest heritage.

—☆☆—

#### USE OF 95 TO 98 PER CENT OXYGEN

Congdon and Burgess of Providence, Rhode Island, in the New England Journal for August 24 report forty cases of abdominal distention and three cases of subcutaneous emphysema treated with 95 to 98 per cent oxygen. Their results were sufficiently satisfactory to justify further use of this strength oxygen in this group of cases.

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## The Use of Insulin in Toxic Hallucinosi\*s

HOSEA W. McADOO, M.D., and  
CURTIS T. PROUT, M.D.,  
Arlington, Mass.

Since 1928 when Sakel<sup>1</sup> first began his studies on the subject, the application and uses of insulin have become increasingly widespread in the treatment of psychiatric conditions. Its use and development has been, from the first, along somewhat empirical lines, the results progressively justifying further study and consideration. Dr. Sakel's own technique of insulin shock treatment of schizophrenia grew out of observations made by him, in the course of the attempted treatment of morphine addicts.

Still later and particularly recently, insulin technique has been carried into the field of alcoholism and the symptoms accompanying withdrawal of alcohol. We have employed insulin in cases of morphine withdrawal, and also in the shock treatment of the psychoses, as in schizophrenia. While our work with the schizophrenic has shown encouraging results, as will be later reported, our statistical reports are not on the high average reported by Dr. Sakel.

The application of insulin to the unpleasant symptoms of morphine withdrawal has won our enthusiastic approval, but it is to be emphasized that this is in relation to the withdrawal symptoms rather than in relation to its playing any part in the maintenance of freedom from the habit itself, or in correcting the personality defects underlying this habit.

On the basis of Dr. Sakel's explanation for his application of insulin to the treatment of morphine addicts, that is, "that insulin abolishes the phenomena of irritation during abstinence from morphine, because the nerve cells were blocked, and their function quantitatively affected," we began using insulin in an attempt to effect a less disagreeable symptomatology during the withdrawal of alcohol.

Meeting with some, but rather variable success, we were further led to apply the method to

cases of alcoholism associated with abnormal mental phenomena, particularly with hallucinosis. This interest began with the treatment of the first of this series of cases in October, 1937. At about the same time, Dr. G. W. Robinson<sup>2</sup> was working independently along similar lines and in November, 1937, he published the results found after treating his first series of nine cases. His findings, as contained in his report, closely parallel those made by ourselves.

The material has been selected from the consecutive admissions presenting evidence of hallucinatory phenomena of persistent nature, following over-indulgence in alcohol. There are those cases in which there is a very transitory hallucinatory episode, clearing in a few hours after withdrawal, and apparently dependent upon the actual presence of the alcohol itself. For this series, the cases were chosen in which the hallucinations seemed of more permanent nature; that is, they continued beyond the immediate stage of withdrawal, or made their appearance following the withdrawal of alcohol. The hallucinations were, in most cases, of both auditory and visual types, with those of auditory nature observed alone in three cases, and the visual type observed alone in only one case.

In the treatment, the size of the dosage of insulin varied from a minimum of 10 units to a maximum of 25 units. The initial dose did not exceed 20 units, and was not made according to any specific rule, with respect to frequency, or to the size or weight of the patient. The reaction to dosage has been found to be extremely variable, with pronounced hypoglycemia resulting from injections of 10 and 15 units respectively, in men weighing 237 and 163 pounds. This factor of uncertainty has caused us to regard even these dosages of insulin with a large degree of respect, and has made us feel that a nursing personnel trained in the observation of

\*Read at the Ring Sanatorium and Hospital, Arlington Heights, Massachusetts, on January 24, 1939 at the annual joint meeting of the Arlington and Belmont Doctor's Clubs.



cases receiving insulin therapy is absolutely essential. The repetition of dosage has been largely dependent upon the needs of the individual, with a maximum frequency of every 2¾ hours. The largest number of treatments required was 11, for a total dosage of 95 units, although 135 units were given in a smaller number of doses in another individual. In retrospect, it is easily discernible that in some instances there has been a tendency to discontinue treatment too early. The insulin therapy was abolished in those instances with the first disappearance of the hallucinations, but we found that after a lucid interval the hallucinations were prone to reappear. Wherever the therapy was continued for at least twenty-four hours after the first disappearance of hallucinations, as in case #70, the treatment was most satisfactory.

For comparative study, a similar number of cases of chronic alcoholism with hallucinations treated by means other than insulin, has been chosen at random, but all of them fall within a contemporary period of time. In these cases the procedure consisted of the withdrawal of alcohol, hydrotherapy in the form of neutral tubs, eliminative procedure, in the form of fluids and catharsis, and the employment of such sedation as seemed indicated, in the form of sodium amytal or paraldehyde. These measures were also employed in the cases that were treated with insulin. In some of the cases in both series, thiamin was used, but not consistently, and it appeared to play no part in these results.

Case #41 F. H. A white male, 37 years of age, with a history of heavy drinking for the past seven years. No history of any previous attack with hallucinosis was obtained, although he had taken treatment for his alcohol addiction several times. Four days prior to admission he went to a camp to get away from drink. Two days after his last drink he developed hallucinations which continued until his admission here on November 6, 1937 at 3:40 a.m. On admission the physical examination showed nothing remarkable and he was given 15 grains chloral, 30 grains bromides and 2 oz. of whiskey. He was actively hallucinating in both auditory and visual fields. He saw gangs of men cutting up people, heard them calling to him, and would keep picking imaginary objects from his bed clothes. He was not violent, however, but lay quietly in bed, talking about the things he saw. At 11:20 a.m. he was given 20 units of insulin. Although he was quiet, the hallucinations continued until about 6 p.m. after which there was no further evidence of them. Without further sedation he slept 8½ hours that night. He was discharged on November 24, as recovered.

Case #46 C. T. A white male 43 years of age. The patient had been drinking to excess for the past seven years. Two years prior to admission he had an attack of hallucinosis lasting two weeks. These hallucinations concerned animals in his room, and were reacted to with panic. He was admitted to the hospital on October 29, 1937 at 2 p.m. There was some unsteadiness and tremor, but no evidence of hallucinations. He was given a neutral tub, 15 grains of chloral and 30 grains of bromides, as a sedative, but slept only 2½ hours that night. On the evening of the thirtieth he would not remain alone in his room; he stated that he was afraid. Later he began talking to himself; he complained of seeing lizards, dogs and ghosts in his room, and slept a total of only 1¼ hours. The following morning he was very disturbed and fearful and thought that the room was filled with dogs, cats and mice. At 8 a.m. 10 units of insulin were given, and at 10:30 a.m. 20 units. Following this he lay quietly in bed, and although he continued to have visual hallucinations, he did not appear frightened. He ate a good dinner. In the afternoon he again became agitated and fearful and would not remain in his room because of animals. At 2:15 p.m. he was given 20 units of insulin and 20 units more were given at 3:30 p.m. He lay quietly in bed during the remainder of the afternoon. At night he again became restless, and although he gave no evidence of fear, he walked around the ward looking into closets and rooms for articles he believed he had lost. 20 units of insulin were given at 7:30 p.m. and 10 units at 10:25 p.m. as well as four grams of paraldehyde. The following morning he was quiet, agreeable and clear, and gave no evidence of hallucinations from that time on. He was discharged on November 6, 1937 as recovered.

Case #60. A white male, 51 years of age. He had been drinking to excess irregularly for the past four years, and had been on his latest episode for two weeks, then stopped abruptly on November 1, 1937. On the 4th he became suspicious that people were watching him. On the 5th he was fearful, restless, and complained of black spots on his bed clothes. He continued to be restless and fearful throughout the day and night and at 5:40 a.m. on November 6, 1937 he was admitted to the hospital. He had received an unknown amount of morphine from his physician prior to admission. Physical examination showed a markedly enlarged liver. The patient remained quiet and drowsy most of the day, but he gave evidence of visual hallucinations and talked of "the gang." The drowsiness disappeared later in the day. He was given 10 units of insulin in the evening, and slept 6½ hours. The following morning he appeared mentally clear, and comfortable. He was discharged on November 19, as recovered.

Case #68. A white female, 51 years of age. The patient had been drinking constantly for three months prior to admission to the hospital. More recently she had also been taking various barbiturates. She was admitted to the hospital at 5:30 p.m. on May 25, 1938. She was unsteady on her feet, and was quite restless, but gave no definite evidence of hallucinations, although she insisted on having the light left on all night in her room. She received 3 grains of sodium amytal twice during the night, but slept only 3½ hours. The following day she was agreeable, but restless, and tried to go upstairs frequently

although she gave no reason for this. The second night she slept 6 hours, with the aid of 3 grains of sodium amytal. The following day she was found talking to herself frequently during the day. That night she became obviously hallucinated, in the visual and auditory spheres. She saw her son in the room, and heard her mother calling to her. The next day May 28th, she reacted violently to hallucinations, struggled to go upstairs where she "heard Thelma calling her." At 9:35 p.m. she was given 15 units of insulin. She was quiet from about 10 o'clock until midnight, when she again became noisy in her reaction to auditory hallucinations. At 1:30 a.m. she was given  $\frac{1}{4}$  grain of morphine by the physician on duty. She slept after this for five hours. When awaking she was violently disturbed, screaming for someone to save her. At 8:55 a.m. she was given 20 units of insulin, but she continued to be noisy until 9:30 a.m. then became quiet and slept from 10 a.m. until 1 p.m. A hypoglycemic reaction developed and she was given 1,000 cc. of 10% dextrose in normal sodium chloride. At 2 p.m. she was quiet and cooperative, and free from all evidence of hallucinations. There was no further evidence of hallucinations during her stay here, although being a court committant, she remained until July 13, 1938.

Case #69. E.J.H. A white married woman, 42 years of age. She was admitted to the hospital on June 13, 1938. The history revealed she had been drinking alcohol to excess for several weeks. On the day of admission she began to hallucinate, hearing voices berating her. On admission she talked of imaginary pictures on the wall. The physical findings were not remarkable. She was fairly cooperative, but was actively hallucinating throughout the first day, and was quiet and comfortable through the first night. She continued to react to hallucinations throughout the second day, and at 8:50 p.m. she was given 15 units of insulin. Following this she was quiet. Though no hypoglycemic reaction was noted, she was given orange juice at 11:30 p.m. She became somewhat restless, and remained so throughout the night. She reacted to hallucinations of an auditory nature on the morning of the third day and was given 20 units of insulin at 12:05 p.m. At 1 p.m. she was somewhat drowsy. She was given orange juice at 3 p.m. 20 units of insulin were given at 8:14 p.m. and orange juice at 11 p.m. There was no reaction from the insulin. The patient slept at 12:45 a.m. The following day she was pleasant and agreeable and gave no evidence of hallucinations, nor did they return during the remainder of her residence in the hospital. She was discharged on June 19, 1938 as recovered from acute alcoholic hallucinosis, although she was advised to remain longer.

Case #59 D. H. Jr. A white married male, 31 years of age, occupation, clerk. He was admitted to the Hospital on November 4, 1937. The history revealed that he had been drinking alcoholic liquors to excess, periodically, since the age of 27. He had made several attempts to effect a cure, without success, but in July or August of 1937 he completed a modified Towne-Lambert treatment, and following this substituted periodic overdoses of phenobarbital or bromides. Ten days prior to admission he began to have auditory hallucinations, was drowsy, and walked with a staggering gait, following the ingestion of what was described as an overdose of his tablet. On ad-

mission he was at first quiet and cooperative, and the physical examination was not remarkable except for an unsteady gait and the fact that he was considerably overweight. Throughout the first four days of hospitalization he continued to react to auditory hallucinations in spite of treatment with sodium chloride, hydrotherapy, and efforts to increase elimination. On the third day he was given 20 units of insulin at 11:20 a.m. At 2 p.m. he perspired freely, pupils were contracted, and he became drowsy; at 2:20 p.m. he lapsed into deep coma. 25 grams of glucose were given intravenously at 2:40 p.m., with effect, followed by a nasal feeding of 240 cc. of orange juice and 150 cc. of 33  $\frac{1}{3}$ % glucose. Following this he could be readily aroused. That night he slept about four hours, or approximately the same as on previous nights. On the fourth day he received no insulin, but on the fifth day he was given 10 units at 8:30 a.m. On the sixth day he was given 10 units each at 7:30 p.m., 10 p.m. and 2 a.m. of the seventh day. Throughout the sixth day he became more quiet, and at times perspired rather freely. On the seventh day he was given 10 units of insulin at 7 p.m. and 10:20 p.m. He continued to react to hallucinations, but not as sharply as before. On the eighth day he was given 15 units of insulin at 10:45 a.m. and 10 units at 10 p.m. On the evening of the seventh day he complained of both auditory and visual hallucinations, for the last time during his residence in the hospital. The following morning they had entirely disappeared and he was discharged on November 24, 1937 as recovered from an active hallucinosis, which was regarded as brought about by the combined effect of excessive use of barbiturates, bromides, and alcohol. No test was made for bromide content of the blood.

Case #70 J.F.C. A single white male, a lawyer, 35 years of age. He was admitted to the hospital on July 8, 1938. The history revealed that for ten months prior to admission the patient had been drinking alcohol to excess, periodically. He was said to have used no alcohol since July 3rd, but on July 4th and 5th to have taken 8-10 capsules of nembutal in a strength of 1  $\frac{1}{2}$  grains per capsule. Following that he developed auditory hallucinations of a persecutory nature. At the time of admission he was restless, and experienced auditory hallucinations. Physical examination was not remarkable, except for a moderate tortuosity of the retinal arteries, and hyperactive deep reflexes. An hour and a quarter after admission he was given 15 units of insulin (4.45 p.m.). At 5:10 p.m. he was given fruit juice. At 7 p.m. he was sleeping soundly, but at 7:45 p.m. his pulse was slow and his head was covered with perspiration. He was given fruit juice, but at 8:30 p.m. there was again evidence of profuse perspiration, and he was given 50cc. of glucose intravenously, following which he aroused and responded to questions. At 10:25 p.m. he said he was talking to an imaginary someone, then laughed. He slept comfortably for the remainder of the night. The following day 15 units of insulin were given three times, followed in each instance by increased perspiration. On the morning of the second day he was quiet and cooperative, rapidly becoming more rational, and gave no further evidence of hallucinatory experience from the evening of the first day. Accompanying treatment consisted of the use of hydrotherapy, elimination, and mild sedation in the form of small doses of bromides and chloral.



He was discharged on July 14, 1938 as recovered from post-alcoholic hallucinosis, with a note that barbiturates may have played a part.

Case #53. A married white woman, an American housewife, 48 years of age at the time of her first admission. She was admitted on June 14, 1937. The history obtained from her husband indicated that she had been drinking unknown quantities of alcohol for at least two weeks prior to admission. She had been under treatment for hypertension for 2-3 years, the blood pressure being 200 and over. For one week prior to admission she complained of auditory hallucinations — people next door accused her of entertaining men during her husband's absence. Following admission she was excited and crying, and the hallucinations continued. She was given thiamin, neutral tubs, and bromides at night. On the second day the hallucinations continued, and were very disturbing to the patient. She was weeping, and refused to eat. She was given sodium amytal at 8:45 p.m. and she slept for one-half hour, then was awake and hallucinating except between 5 and 7 a.m. when she slept. From the third day, until the 30th, or 16 days, she continued to have active auditory hallucinations, was often very excited, resisting her imaginary tormentors. Treatment continued in the form of hydrotherapy, elimination, and sedation. The hallucinations cleared on the sixteenth day, but she remained in the hospital until August 6th when she was discharged as recovered from acute alcoholic hallucinosis.

The patient was re-admitted on June 23, 1938 with a history of three weeks of excessive drinking of alcohol, mainly socially, the amount being unknown. Three days prior to admission she experienced auditory hallucinations of a similar nature to those of her first admission. Physical examination showed the heart slightly enlarged to the left, blood pressure was 170/120 and there was a moderate tremor of the outstretched hands. She reacted to auditory hallucinations in a noisy, disturbed fashion, talking out of the window. She was resistive and combative at times, for the first 40 hours, in spite of hydrotherapy and eliminative treatment. She refused medication during that time, and slept none. On the third day she was given 20 units of insulin at 10:05 a.m. She became more quiet and cooperative throughout the remainder of the day, but in the evening became more active, again reacting to auditory hallucinations and talking out of the window. She was given a sedative at night and slept  $5\frac{1}{2}$  hours. She slept through the morning of the fourth day, ate well, and was quiet and cooperative, though slightly depressed, until the fifth night when she again reacted to hallucinations of an auditory character. On the morning of the 6th hospital day, she was given 20 units of insulin at 11 a.m. and the same treatment was repeated at 3 p.m. She continued to be very restless throughout that day and night, and slept none. On the 7th hospital day 25 units of insulin were given at 9:30 a.m. and at 3:00 p.m. She continued actively hallucinating, but at night, with a sedative, slept six hours. On the 8th hospital day she received 25 units of insulin at 10:50 a.m. At noon she became drowsy. That night she slept well the first part of the night, but she awoke at 2:45 a.m. disturbed and hallucinating. She slept again at 3:15 a.m., obtaining a total of  $8\frac{3}{4}$  hours sleep, with less sedative than the previous night. For the

next two days she was quiet and cooperative, and gave no evidence of hallucinatory experiences; then, on the 10th hospital day she again reacted to hallucinations which continued throughout the 11th day, but they were not of such severe character as previously, as evidenced by her mild reaction to them. On the night of the 11th day she slept quietly and experienced no further delusions or hallucinations during her residence in the hospital. She was discharged on July 30, 1938 as recovered from acute alcoholic hallucinosis.

From Table I, it may be seen that in the treated series there were two cases in which the alcohol was complicated by the use of barbiturates, and in one of these, also by bromides. The alcoholic picture, however, seemed to predominate sufficiently to permit their inclusion. In case #53 we were fortunate in having the opportunity to observe two different admissions of the same patient, in the first of which insulin therapy was not used, and in the second of which it was used. As in the series, the individual comparison reflects favorably upon the use of insulin by the fact that the period of hallucinations was considerably shortened in the second admission.

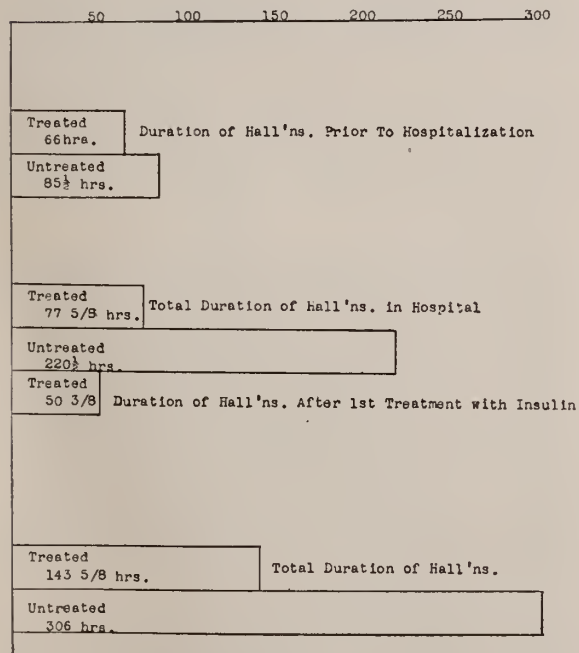
The effect of the injections was largely sedative, with definitely and progressively decreasing evidence of severity in the reaction of the patient to the hallucinations. The most striking observation from a review of the cases may be seen in Table 2. There we find that the average duration of the hallucinations during the hospital residence in the treated series, is definitely less than it was in the untreated series. Carrying this a step further, we find that upon subtracting the average number of hours of active hallucinosis in the hospital, prior to treatment with insulin, from the total hours of hallucinosis in the hospital in the untreated series, we have a figure revealing a still greater and even more striking contrast. It is interesting to compare our average figure of  $50\frac{3}{8}$  hours of continued hallucinations following the institution of insulin therapy in the treated series, with the report of an average of 115 hours as given by Piker and Cohn<sup>3</sup> on a series in which they used a treatment consisting of spinal puncture, glucose, and paraldehyde, and with those of G. W. Robinson with 79.2 hours in untreated cases, and 31.2 hospital hours in the treated series.

No attempt was made to obtain a hypoglycemic reaction, and the oral ingestion of sugar in

TABLE 1  
DURATION OF HALLUCINOSIS

No.	Sex	Age	Wt.	Etiology	No. of Attack	Prior to Hosp'n.	Before Ins.	After Ins.	Total In Hosp.	Total	Total Dose of Ins.	Effect on Reaction To Hall's
41	M.	36	115	Alc.	1st.	48 Hrs.	8 Hrs.	7 Hrs.	15 Hrs.	63 Hrs.	20 U.	Mildly Sed.
46	M.	43	180	Alc.	2nd.	0	8 Hrs.	24 Hrs.	32 Hrs.	32 Hrs.	130 U.	Sed.
60	M.	51	166	Alc.	1st.	24 Hrs.	12 Hrs.	0	12 Hrs.	36 Hrs.	10 U.	Sed.
65	F.	51	145	Alc.	1st.	0	24 Hrs.	12 Hrs.	36 Hrs.	36 Hrs.	35 U.	Sed.
69	F.	42	130	Alc.	1st.	24 Hrs.	29 Hrs.	24 Hrs.	53 Hrs.	77 Hrs.	55 U.	Sed.
59	M.	31	237	Alc. Barb. Brom.	1st.	240 Hrs.	96 Hrs.	196 Hrs.	192 Hrs.	432 Hrs.	95 U.	Mildly Sed.
70	M.	35	163	Alc. Barb.	1st.	120 Hrs.	1 Hr.	0	1 Hr.	121 Hrs.	60 U.	Marked Sed.
53	F.	48	119	Alc.	2nd.	72 Hrs.	40 Hrs.	240 Hrs.	280 Hrs.	352 Hrs.	135 U.	Mildly Sed.
53	F.	48	119	Alc.	1st.	160 Hrs.	—	—	384 Hrs.	552 Hrs.	—	—
375	M.	31	200	Alc.	2nd.	24 Hrs.	—	—	336 Hrs.	360 Hrs.	—	—
37	M.	44	136	Alc.	1st.	24 Hrs.	—	—	72 Hrs.	96 Hrs.	—	—
49	M.	43	145	Alc.	1st.	0	—	—	60 Hrs.	60 Hrs.	—	—
52	M.	44	197	Alc.	1st.	72 Hrs.	—	—	576 Hrs.	648 Hrs.	—	—
54	M.	43	212	Alc.	1st.	24 Hrs.	—	—	72 Hrs.	96 Hrs.	—	—
58	M.	40	118	Alc.	1st.	36 Hrs.	—	—	72 Hrs.	108 Hrs.	—	—
67	M.	37	196	Alc.	1st.	336 Hrs.	—	—	192 Hrs.	528 Hrs.	—	—

TABLE 2  
Hours



many instances was encouraged even before the reaction actively occurred.

### Summary and Conclusions:

1. A report is given of the findings in a series of eight cases of chronic alcoholism with hallucinosis, treated with small doses of insulin.
2. In the treated series the hospital hours of hallucinations have been materially lessened as contrasted with the hospital hours of hallucinations in the untreated cases.
3. It has been observed that the severity of the reactions of the patients to the hallucinations is lessened following the insulin injections.
4. The treatment should be continued for a minimum of 24 hours after the cessations of the hallucinations.
5. The possibility of hypoglycemic reactions prompts the provision of skilled observers during the treatment.
6. A hypoglycemic reaction is not regarded as essential in obtaining the desired effect.

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## The State Register of Crippled Children\*

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There is no data available showing the number of crippled children in Connecticut. According to surveys made in various parts of the country, it has been estimated that there are about three crippled persons, eighteen years of age and under, per 1000 general population. On the basis of this ratio, using the calculated population as of July 1, 1939, there are 5,433 crippled children in Connecticut. Because of the wide variety of clinical conditions considered as crippling and acceptable for treatment under the Connecticut plan, this figure is an underestimation. Moreover, persons under twenty-one years of age are eligible for care.

The knowledge of the number of crippled children in Connecticut would be of little value unless other data were available such as the name and address of the crippled person, the doctor or crippled children agency responsible for his care, and the diagnosis.

With this data and whatever additional information may be requested from time to time from the doctor or crippled children agency, the State register will eventually serve the following purposes:

1. To provide a clearing file through which every crippled child may be routed to a doctor or agency (State agency or other) which will render the service indicated by the particular needs of the patient.
2. To provide the statistical data upon which an informed approach to the educational, vocational and occupational needs of crippled persons must be based.
3. To provide statistical data which may be of value in the prophylaxis of crippling conditions.
4. To provide information through which the Division of Crippled Children will be

in a position to direct its activities, geographically, clinically and financially, into channels of greatest usefulness.

5. Eventually the register will provide the statistical yardstick by which the whole program of crippled children activities in Connecticut, public and private, can be assayed. It will ultimately indicate how completely the needs of crippled children are being filled, emphasize the fields of activity in which public and private agencies overlap, and provide the requisite basis for realignment and redirecting of State-wide crippled children activities in accordance with changing conditions and needs.

The conditions to be reported include the following: Congenital, orthopedic and non-orthopedic conditions such as clubfoot, dislocated hip, cleft palate, harelip, and so forth; heart disease; acquired orthopedic conditions such as poliomyelitis, arthritis, birth injuries, and so forth; rheumatic heart disease; contractures resulting from burns.

It is hoped that every crippled child, whether under private or public care, will be registered. Therefore, in order to make the register complete it is essential that physicians and surgeons, hospitals and dispensaries, and private crippled children agencies report these cases to the Division of Crippled Children. The names on the register will be held in the strictest confidence. Further information about cases will be requested only from the doctors or agencies caring for the children.

The register will help to ensure that no crippled child is overlooked and that no case lapses from treatment because of change of address or because of change in financial circumstances.

\*Read at 147th Annual Meeting, Connecticut State Medical Society New Haven, May 25 and 26, 1939.

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# Scoliosis: A Rational Form of Treatment<sup>\*\*†</sup>

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Hippocrates coined the generic title "Scoliosis" and called it the spinal sign of muscle-bone imbalance of the back — not a specific disease. Andry-Paris in 1744 made first use of the term "orthopaedic," deriving the term from his studies in scoliotics. Thus the study of scoliosis becomes the oldest condition classified under the now greatly expanded title, orthopedics. Furthermore, but little can be added to the definition stated by Hippocrates although two thousand years have passed.

Fully 85% of the cases seen in the average clinic constitute the so-called idiopathic type described by Hippocrates. Because of the confusion generally associated with this condition, the author wishes to present a rational classification:

## Classification of Scoliosis

### I. Functional

### II. Structural

#### A. Bone Changes

- (1) Congenital 1-2%
- (2) Thoracogenic
- (3) Rickets
- (4) Osteomalacia
- (5) Osteogenic imperfecta
- (6) Tuberculosis, etc.

#### B. Nerve Changes

- (1) Postpoliomyelitis 5%
- (2) Syringomyelia
- (3) Frederick's Ataxia
- (4) Cerebro-spastics, etc.

#### C. Muscle Changes

- (1) Muscular dystrophy
- (2) Muscle infections
- (3) Idiopathic (imbalance) 80-85%

#### D. Growth Changes

- (1) Infantile, 0.5% diminished rib growth, hemi hypertrophy, etc.

Carey and Harrenstein have thrown the most light on the idiopathic and infantile types. The former has shown greater muscle weight loss on one side of the spinal column than on the other in marasmic infants. The skeletal growth persists with a resulting asymmetric pull due to focal muscular atrophy. Thus he believes that malnutrition or under nutrition is a dominant underlying cause.

Harrenstein has measured the length of rib growth in dried specimen and found the inequality of growth present in ribs that have produced rotation of a vertebral body with secondary scoliosis. Be that as it may, we have to deal with a complicated set of structures only one of which is muscle substance. Yet there are thirteen paired spinal muscles presenting 67/M possible combinations of pulls or stresses. There are 144 muscles, in all, attached to the vertebral column with one billion possible combinations of stresses and effects. This physiological system of movement also involves effects produced by blood vessels, nerves, over-lapping tendons, shapes of opposing bone surfaces and capsules of joints limiting motion, rapidly passing into possibilities beyond comprehension.

I propose to present a preliminary report of two forms of treatment of this very complex problem.

## TABULATION OF HISTORICAL REVIEW (in brief)

<i>Guerin</i>	1830—Myotomy performed.
<i>Lintz</i>	1885—Sweden — Gymnastics.
<i>Volkman</i>	1889—Costal resection to remove gibbosity only.
<i>*Chipault</i>	1900—Fixation of spine with wire between spinous processes.
<i>Steindler</i>	1909—Development of Compensatory Curves.
<i>*Hibbs</i>	1913—Spinal Fusion.

<sup>\*\*</sup>(From the orthopaedic services of M. K. Lindsay, M.D. and R. M. Yergason, M.D., Newington Home for Crippled Children, Newington, Connecticut.)

<sup>†</sup>Read at 147th Annual Meeting Connecticut State Medical Society, New Haven, May 25 and 26, 1939.



<i>Haglund</i>	1916—Muscular insufficiency overcome by derotation jacket correcting lumbar curve — forcing dorsal curve to correct itself through the body righting mechanism.
<i>Schanz</i>	1923—New principle, single pressure point spinal brace.
<i>Steele</i>	1928—Elevation of one side fifth lumbar by bone wedge.
<i>Risser</i>	1928—Turnbuckle Correction Jacket, recumbent.
<i>Brewster</i>	Turnbuckle Correction Jacket, erect.
<i>Harrenstein</i>	1929—Described and treated infantile types
<i>* Kreutscher</i>	Fused entire spine.
<i>Galeazzi</i>	Derotation machine and plaster.
<i>* Hibbs and</i>	1930—Turnbuckle Jacket and spinal fusion.
<i>Risser</i>	
<i>Hauser</i>	1932—Muscular insufficiency (Haglund).
<i>*Ferre</i>	Fused lumbar curve and lumbosacral junction.
<i>Von Lackum</i>	1933—Removal of vertebral body.
<i>Fitchel</i>	1934—Abduction deformity, contracture of fascia lata, caused pelvic tilt and scoliosis, generally postpoliomyelitis.
<i>Sulro</i>	Geometric analysis of spine — theoretical value only.
<i>Baeyer</i>	1936—Three point pressure correction jacket, erect, later used by Barr.
(Berlin)	
<i>* Risser and</i>	1936—End results of Turnbuckle Jacket
<i>Ferguson</i>	and fusion — best result, 79%.
<i>Malamud</i>	Mental experience condition adolescents, may lead to faulty posture and scoliosis.
<i>*Goodwin</i>	1938—Bone traction by means of steel wires through spinous processes and plaster jacket.
<i>Abercrombie</i>	Adolescent type due to bashfulness with change in attitude. Modesty producing a defensive reaction with change in posture?
<i>*Smith</i>	Risser jacket and spinal fusion.

In the list given of outstanding contributions there were eight references which indicate the trend of treatment of scoliotics today presenting the highest percentage of good results. This form of treatment is that of a turnbuckle correction plaster jacket plus spinal fusion to maintain correction.

Since the three elements of a fully developed scoliosis are

- (1) Curvature of spine in frontal plane,
- (2) Shifting of torso in frontal plane with regard to pelvis,
- (3) Deformity of thoracic cage due to torsion of spine,

can a turnbuckle jacket have the desired effect in correction? The first two present little difficulty but the third is another matter. Some

correction of torsion of spine takes place by derotation within the jacket at time of lateral correction. However, the razor back case does not respond to derotation although the lateral correction may be quite satisfactory. They still have their gibbosity unless the posterior chest wall deformity presents a more gradual curve on which the mechanical forces can act. Then derotation takes place; the chest slips around and is corrected together with the lateral deformity. It would appear that the mechanics of derotation require a relatively smooth gliding surface within an arc of a circle for effective application. The degree of correction depends upon the mobility of the spine and the amount of structural change present. Younger children are more mobile and permit greater correction. Less correction is obtained in the high dorsal region than in the low dorsal and lumbar areas. The longer the curvature has existed, particularly in paralytic cases, the more difficult is correction.

Most of the idiopathic or habitual cases, together with all of the mild rachitic cases, can be controlled by conservative means; special exercises and improvement in general health. These constitute about 35% of the cases seen in the average clinic. None of the paralytic cases, however, should be treated in this way for more than a reasonable period. They will all grow worse as far as the curvature is concerned. Plaster corsets and braces are not recommended. If these little patients are going to show an increase they will do so even within a corset or brace.

When a child is first seen in our clinic, its condition is recorded in the following manner:

Standing Height  
Sitting Height  
Weight  
Leg Lengths  
Roentgen Studies — 7 views  
Posture Photographs — 4 views  
Muscles are charted.

Instructions in postural exercises are given and child is encouraged to rest 12-16 hours a day if curve is less supine than standing. Unequal legs are balanced by raises under shoes. Child is followed at four month intervals and checked for increase in curve. As soon as this appears, child is considered for admission, application of correction turnbuckle jacket followed by fusion.

Indications for Risser treatment are:

- (1) Over 4 years of age and curve increasing.
- (2) If over 16 years of age and curve is grotesque.
- (3) Back pain persisting.
- (4) Marked fatigue.
- (5) All paralytic cases — because we know they will grow worse inevitably.

The turnbuckle jacket is allowed to correct slowly, to the point of tolerance or until desired correction has been reached. Do not over correct. The posterior portion is then fenestrated and the primary curve fused from sound vertebra to sound vertebra. The cervical region is never fused. Five or six vertebrae are fused at a time for sake of safety. The children tolerate it well and require about 4 to 8 weeks between fusions. The modified Hibbs operation is preferred plus an implant from the tibia or os purum. The children are then kept recumbent 3 or 4 months longer and plaster changed for a lighter jacket with shoulder loops. This jacket is worn 3 months and next jacket is applied without shoulder loops. Child is then allowed to sit up and soon is walking. A supportive jacket is worn for a year or longer. Risser reports 10% loss of correction during this period. Others report even greater loss of correction.

#### Causes of Failure

1. Insufficient postoperative immobilization.
2. Fracture of implant.
3. Pseudo-arthritis or sloughing of implant.
4. Too many or too few vertebrae in fusion area.

Our first six cases averaged 55 weeks hospitalization at a cost of \$1050 per case. The next six averaged 62 weeks at a cost of \$1200 per case. Complications of respiratory infections, etc. can prolong the time element and must be expected. We are now trying to reduce hospital weeks by speeding up time of correction before fusion through the medium of improved padding, better jackets and shorter periods between fusions. You can see how comprehensive and how costly this form of treatment is in order to secure measured results of a good quality. To date our results appear satisfactory but a five year period is necessary for worthwhile computations.

Infantile scoliosis will respond to recumbency

on a curved Bradford frame or in a curved correcting plaster shell. This is followed by six hours a day on face, wearing a canvas correcting corset. A year is generally necessary for correction in most cases. A five year follow up is urged in every case.

This will constitute a preliminary report on the work which is progressing at Newington Home for Crippled Children with results to be reported later.

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## Herniation of Intervertebral Discs.\*

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In recent years a widespread and rapidly growing interest has developed in connection with conditions which stenose the spinal canal. It has long been recognized that certain abscesses, arthritic growths, tumors, foreign bodies and fractures of the spine could have a stenosing effect on this canal and that any degree of cord and nerve root dysfunction could result from the destruction caused by such masses. In the last decade the work of Schmorl lead to knowledge that the neucleous pulposus, the semi-solid center of the intervertebral disc, could by reason of the force of compression rupture the disc, and that the resulting displacement was typically dorsalward into the canal. This is due, of course, to the fact that the longitudinal ligament completely surrounding not only the body of the vertebrae but also spanning the intervertebral space (and consequently the intervertebral disc), is weakest on its dorsal lateral aspects. Mixter and Barr by 1934 recognized that many of the cartilagenous intraspinal tumors that had from time to time been removed because of neurological symptoms had as etiology rupture of the disc.

Reports of this or similar conditions have appeared from time to time:

1. Elsberg in 1913 reported a case of compression of nerve roots following trauma. Operative removal of a thickening of the ligamentum flavum was followed by complete relief of symptoms.

2. Mixter and Barr in 1934 reported a series of cases of rupture of the intervertebral discs with involvement of the spinal cord.

3. Barr in 1937 reported a series of forty cases of sciatica caused by intervertebral disc lesions.

4. Love in 1939 reported a series of two hundred cases of rupture of intervertebral discs.

In reviewing the literature we find enlarge-

ment of ligamentum flavum and rupture of nucleus pulposum frequently referred to as the cause of intractable sciatica, despite the fact that the history and symptoms of patients with these conditions are essentially the same as those of herniation of intervertebral discs. We believe it is impossible to differentiate clinically between them.

One of our cases in 1937 was diagnosed and operated elsewhere and it was then that the present authors came to wonder how many patients with low-back and sciatic pain seen by them might suffer from nerve pressure due to stenosis of the spinal canal from the cause under discussion.

The results to be reported are simply such as we feel might be typical for others, outside large medical centers, who are interested in the handling of such patients. Our work has not been original: we have simply applied the method and procedures described in the literature. Our experience would indicate that the condition of chronic pain and disability from stenosis of the spinal canal may be much more common than is generally supposed. Our follow-up observations have in no case been longer than two years. We realize, therefore, that in that sense at least this can only be a preliminary report, for a perfect follow-up would extend to the death of the patient. None of our operated cases has died.

The cases here being reported have been selected from among the private patients of the senior author. Of those who complained of low-back pain, sciatica and other neurological symptoms, twelve patients have had intradural lipiodol injection and one case was diagnosed without such help.

### History

( Patients have been selected primarily because of intractable pain coupled with weakness. By

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intractable we mean that the usual measures of treatment had failed to bring relief. In one case the appendix had been removed as a measure of treatment and in another only its previous removal had prevented the diagnosis of appendicitis. In all cases, resort had previously been made to cultists. Traumatic history varied from fractured vertebrae to no history at all, but ten patients attributed their illness to a definite injury.

### Symptomatology

The duration of symptoms varied from nine months to twenty-nine years. Low-back pain with intractable sciatica was the most constant complaint and in most patients was so severe as to require bed rest and narcotics. Remissions and recrudescences of symptoms were the rule. Severity of symptoms required that three of these patients be first seen in their homes and be transported by ambulance to the hospital: another patient insisted that he had been unable to sit down to a meal for three years prior to operation. Six patients complained of occipital headaches. Coughing, sneezing, straining at stool and sudden change in position usually exaggerated the sciatic and low-back pain. Subjective loss of or diminution in sensation over areas supplied by the lumbar and sacral segments was noted in all patients, these changes ranging from slight numbness to definite paralysis. Urinary incontinence and lack of proper bowel control were present in two cases. Eight patients complained of motor weakness of one or both lower extremities.

### Examination

All patients exhibited abnormal posture, reduction or elimination of normal lumbar lordosis, spinal rigidity, lateral tilting of the pelvis and decided list on walking or standing.

Palpation consistently showed tenderness over the spines of the lower lumbar vertebrae and along the sciatic nerve; also lumbosacral muscle spasm very slight in one, moderate or severe in the others.

Other common findings consisted of general limitation of movements of the back and limitation of straight leg raising tests, most pronounced on the side of the sciatica and the list. Motor weakness was frequent in the tibial and gluteal groups. Paresthesia or complete sensory loss was found in all cases. The most constant

neurological finding was decreased or complete loss of Achilles reflex on the side of the sciatica and the list: this was absent in only one case. Our experiences point to the great value of orthopedic examination in these cases. It is not required that abnormal neurological conditions appear before seriously considering the possibility of stenosis of the spinal canal. ]

### X-Ray Examination

Routine A. P. and Lateral views were taken of the lumbar and pelvic areas in all cases, also Obliques in both directions in the lumbar area. All our cases showed some degree of arthritis: in one instance there was pronounced reduction of the fourth lumbar interspace, and in another Schmorl's nodes appeared on the adjacent surfaces of the second and third lumbar bodies. In both these cases the stenosing factor in the canal was found at the level of the changes visualized on the films. Lack of normal lordosis appeared. These changes, even though all present, are not considered sufficient basis for a definite diagnosis of stenosis.

### Spinal Fluid Examination

Where there is intraspinal pathology the total protein content of the spinal fluid may be increased, causing an increase in the specific gravity and gravitation of that fluid to the bottom of the caudal sac. Consequently, in order to obtain the best information in this regard, the tap should be done distal to the level of the pathology, and only the first two or three cubic centimeters of fluid discharged should be used for the examination.

In this series no instance of complete block to spinal fluid was found. In each case the only specimen sent for examination before the report of total protein content was returned, was that of the first two to three cubic centimeters drawn. Only three cases of protein content greater than normal were reported. Probably this number would have been greater had we in all instances made the tap distal to the stenosing factor.

We have found help not so much from knowing whether the total protein value was normal or high, but in knowing whether the value was very high. One of our cases proved to have a cord tumor and the exceedingly high total protein value was one flag directing our attention to



the possibility that other than a prolapsed disc was to be dealt with.

Our routine is to make the tap with the patient on the fluoroscopic tilt-table and to leave the needle in situ until report of the examination has been returned; then to send an additional specimen for such other tests as may be desired in measures of general examination.

### X-Ray Search For Stenosis Of Spinal Canal

This is the high point of the work-up. We have not learned of the work of others who have made (to us at least) a convincing negative search for stenosis, and who have at the same time eliminated the use of contrast media. The contrast media used has been Lipiodol intraspinally.



Figure 1.

P. N. A. P. Roentgenogram shows normal filling of the caudal sac.

In one patient not included in this series, painful irritation followed the injection of Lipiodol by others in an out-of-town institution. No stenosis was demonstrated. The complication was readily relieved by an original procedure which to date we have not seen reported. By drilling the sacrum and inserting a curved trochar through the dura with the patient in an upright position, the escape of the oil was permitted. In another case the patient was sent home several

hours after injection, but an hour after arriving there his house caught fire and he took part in combatting the blaze, disregarding his instructions to rest in bed. During the next day he required two doses of morphine to control his sciatica, this time bilateral, after which, until operation a week later, he seemed to suffer no more than before injection.



Figure 2

P. N. Lateral Roentgenogram shows normal filling of caudal sac.

The fluoroscopic examination is the most important single diagnostic procedure. This is done with patient in prone position on the tilt-table. The Lipiodol column is observed in its flow up and down the spinal canal for any obstructions to its passage. All deviations from normal are checked by repeated tilting of the patient. Filling defects are important only when they are constantly present as to degree and location. Halting of the radio-opaque column at any level indicates obstruction. This may be partial or complete, depending on the degree of tilt and the time allowed for the Lipiodol column to pass the obstruction. Transposition of visualization of stenosis of Lipiodol column onto x-ray films is not always satisfactory, because it is not possible to arrest the column long enough to permit photography.

Satisfactory x-ray films are obtainable when the obstruction is at either end of the spinal column. It is possible to record filling defects when spot x-ray apparatus is available. Films are best read with the help of the knowledge gained during fluoroscopy.



Figure 3.

G. A. A. P. Roentgenogram shows filling defect at level of fourth lumbar interspace, left side.

### Summary of Cases

Twelve patients have been injected with Lipiodol. One of the early ones showed no obstruction. Of the remaining eleven, three have not been operated. One of these on her original Lipiodol examination was found normal, but during an acute stage three weeks later showed a definite partial obstruction. She is now in remission and, with another of the three holding operation in abeyance. The third of this group committed suicide. The remaining eight have been operated upon: one in New York, and now working in a gas station: two by Dr. German of Yale in New Haven Hospital, who found obstruction extradurally at the site of pre-operative diagnosis. One of these has returned to labor: the other was of eight years complete disability and long bedfast with paralysis. This latter patient has been cured of his pain and now walks with brace and crutches. One was operated upon in Norwalk by Dr. H. C. Fett of Brooklyn,

and extradural obstruction was removed. He has now returned to labor. Three were operated upon by the senior author, who found and removed extradural masses and the patients now pronounce themselves cured. One is a master plumber, one retired, and the other a playwright. The morbidity was low: they were all out of the hospital by the tenth day or sooner and are so far to be considered excellent results by the standards of any surgeon. This leaves one remaining case for discussion. It is different from the others and merits very special consideration because of pre-operative findings suggesting its special character. The patient is a forty-one year old female operated upon in the Norwalk General Hospital by Dr. Tarlov of Brooklyn, who found an inoperable intramedullary cord tumor shown to be a glioblastoma, a benign type of glioma highly non-reactive to radiation and which may only be expected to grow to produce death of the patient from secondary causes. Her first sign of trouble was collapse of the knee-joint which caused her to fall on the floor about five months prior to operation and, contrary to the history given in the other cases, she had absence of early pain. On first examination two weeks before operation she had no localized tenderness where Lipiodol



Figure 4.

G. A. Lateral Roentgenogram shows anterior constriction of dura at level of fourth lumbar interspace.



later showed an obstruction to be, and she was observed to have rapid progression of symptoms and signs. When first seen there was motor weakness of the right lower extremity but no loss of sensation. She was not seen for a week and it was then found that she had motor loss in both lower extremities and sensory loss in the right: then on daily examination until operation she was observed to lose her normal reflexes, develop and lose Babinski's reflex and to progress to complete paraplegia with loss of sphincter control.

### Operation

Bilateral laminectomy has been done in all our cases. We have found use of a coagulating current valuable in control of bleeding. A layer of fat is normally and usually found extradurally within the canal but pressure tends to cause its atrophy. By noting its absence and extending the laminectomy in both directions until it is seen, the exact area of involvement from intradural causes may sometimes be determined before the dura is opened. We have not opened the dura in all our cases, but we plan to open it more readily in the future. In the cases of extradural pressure we have found the normal contour of the dura modified and its color usually dull, until removal of whitish, friable, constricting tissue restored normal contour. No associated fusions have been done and no bone has been replaced on closing.

**Case No. 1.** N. B., male, aged 34, fell downstairs in 1934, landing on buttocks. Complained of right sciatica, low-back and girdling pains. Appendectomy, tonsilectomy and osteopathic methods had failed to cure him.

Examination 6/11/37, revealed some loss of lumbar lordosis, slight list to the right, marked limitation of forward bending and of straight leg raising. There was slight atrophy of the right lower extremity, and moderate hyperesthesia on anterior surface of the left; also moderate tenderness over the right sciatic nerve and in mid-line of low lumbar region. Diagnosis of herniation of an intervertebral disc was not made. Patient was sent to New York Hospital, where Dr. Wray did an exploratory laminectomy and removed soft tissue found to be stenosing the lumbar dura. Prompt recovery followed operation and at present time patient is an attendant in a gas station.

**Case No. 2.** D.D., male, aged 50, stated left sciatic pain began three months after injury of back while lifting heavy sewer pipe and that his condition had constantly grown worse in spite of conventional treatment and osteopathic methods. Sciatic and back pain so acute that he had difficulty in sitting, rising, walking and sleeping, and he had been unable to work for nine months. Coughing or sneezing produced increased symptoms.

Examination showed slight list to left as he started to walk, slight loss of normal lordosis, considerable limitation of motion of the low-back in all directions, atrophy of left gluteal region and marked limitation of straight leg raising on both sides. There were definite sensory losses on external surface of left leg, tenderness over the sciatic nerve and in the low lumbar region, and left ankle reflexes could not be elicited. X-ray showed marked arthritic lipping on all lumbar vertebrae and loss of normal lordosis. Total protein reported normal. Lipiodol showed a definite filling defect on the left side at the level between fourth and fifth lumbar bodies. Laminectomy 6/25/38, by Dr. German in the New Haven Hospital, and a stenosis found and relieved at the location shown by the Lipiodol. Post-operatively there was immediate improvement and patient returned to work as laborer.

**Case No. 3.** M.C., male, aged 52, with history of trauma questionable. Complained of low-back pain and left sciatica of eighteen months' duration. Unable to work.

Examination showed list to left, flat back muscle spasm in lumbo-sacral region, localized tenderness in spines of fourth and fifth lumbar vertebrae, weakness of left lower extremity, sensory changes on lateral aspect of left leg, atrophy of left gluteal groups, and loss of Achilles reflex. X-ray examination showed marked arthritis of lumbo-sacral region of back. Spinal fluid protein reported normal. Lipiodol examination showed filling defect at level of fourth interspace. Operation 11/8/38 showed stenosis at level shown in examination. Returned to work as laborer in the twelfth week.



Figure 5.

M. C. A. P. Roentgenogram shows bilateral filling defects at level of fourth lumbar interspace: presumptive defects at next higher interspace.



Figure 6.

M. C. Lateral Roentgenogram shows both anterior and posterior defects at level of fourth lumbar interspace; presumptive defects at next higher interspace.

**Case No. 4.** J. C., male, aged 54. In 1930 he slipped on the floor and sat down hard, resulting in severe back pains which continued with some remissions until operation. Left sciatica developed early in his disability and gradually complete paralysis of the left lower extremity resulted. Because of severe headaches and pain in the right lower extremity the patient became almost continuously bedfast five years previous.

Examination showed left monoplegia with paresthesia indicating an involvement of the third lumbar neurological segment and those distal thereto on the left side, with questionable involvement on the right. Left ankle jerk could not be elicited and there was tenderness over the spine of the third lumbar vertebra. Abnormal X-ray findings were nothing more than arthritis in the lumbar and pelvic regions. General examination showed nothing indicative of cause of symptoms. Lipiodol showed a filling defect on the left side at the level of the third lumbar interspace. Dr. German performed a laminectomy on this man in New Haven Hospital on 2/4/39 and removed the stenosing factor from the canal at the level pre-operatively designated. Patient now has complete return of sensation and freedom from headaches. The sciatic tenderness is lost and he walks with the aid of a brace and crutches.

**Case No. 5.** P.B., male, aged 49. Nine months ago the patient over-exerted while helping to carry a bath tub upstairs. At that time he felt sharp low-back pain and girdling pain on the right, which caused muscle spasm and local tenderness, and he was carefully observed for an acute

abdominal condition. Six weeks later he developed right sciatica for which he had much of the usual treatment, also osteopathic treatment without avail and in spite of which he had more pain and developed motor weakness of that extremity. When first seen he showed atrophy of right lower extremity with marked weakness, absence of the ankle reflex, paresthesia of the foot and leg, tilt to right on walking, tenderness over spine of third lumbar vertebra and right sciatic nerve, lumbar spasm and loss of lordosis. Total spinal fluid protein reported 100 mgms. per 100 cc.'s. X-ray showed reduced lordosis and Schmorl's node on the upper surface of the third lumbar body. Lipiodol showed filling defect at second lumbar interspace on the right side. Laminectomy done 2/25/39 and the dura found constricted. Friable, whitish tissue removed from the bony walls of the canal by retraction of the dura and by opening it dorsally and ventrally. Left hospital on fourteenth day and returned to his plumbing business six weeks after operation.

**Case No. 6.** C. B., female, aged 51. Indefinite history of injury. Complained of low-back pain and left sciatica of six months' duration. First seen 3/8/39.

Examination showed tenderness over spines of fourth and fifth lumbar vertebrae, marked lumbar muscle spasm, reduced lordosis, slight list to left on standing, moderated atrophy of the left gluteal group and absent ankle reflex on left. X-ray showed the reduced lordosis. Spinal fluid total protein reported normal. Lipiodol showed questionable filling defect at fourth lumbar interspace. Symptoms and signs increased clinically and patient had difficulty in walking. Three weeks after Lipiodol injection bilateral filling defect was clearly demonstrated by fluoroscopy and films. Symptoms abated and patient still defers operation.

**Case No. 7.** G.A., male, aged 68. No history of injury. Told of suffering three years from low-back pain and left sciatica. Much difficulty in attaining a sitting position and unable to remain sitting long enough to eat. First seen 2/3/39.

Examination showed difficult gait with list to left, lumbar muscle spasm with tenderness over left sciatic nerve and at the lumbosacral joint, lack of normal lordosis, atrophy of left gluteal group and absence of left ankle reflex. X-rays showed some arthritis of the lumbar spine. Total protein value reported normal. Lipiodol marked filling defect at fourth lumbar interspace. Operation 3/2/39 revealed the obstruction to be due to whitish, friable, soft tissue lying between bone and dura. Patient now able to sit down easily and to remain sitting as long as desired.

**Case No. 8.** A.G., male, aged 55, fell from a tree more than a year prior to first being seen. The first lumbar vertebra had been crushed, there had been a complete paraplegia and he had spent a long time in the hospital. When we saw him his sphincters functioned fairly well and he walked with a shuffle and the aid of a cane, but came in because of much low-back and sciatic pain. There was moderate atrophy and loss of sensation of both lower extremities, greatest on the left, tenderness over left sciatic nerve and at level of old fracture. Left ankle reflex absent; right diminished. X-ray showed very good reduction and obliteration of fracture line with suggestion of narrowing of interspace between twelfth dorsal and first lumbar bodies. Spinal fluid was bloody, so total protein value was not learned. Lipiodol showed complete block at level of inter-



space above vertebra that was fractured. Patient was to consider operation: next we heard he had committed suicide.

**Case No. 9.** C. D., female, aged 45, with history of slipping on ice four months before first being seen by the senior author. All treatment had been by osteopaths. Alleged injury to back, right knee and hip. Complained of left sciatica, low-back pain and of paralysis.

Examination in patient's home showed acute tenderness over spines of fourth and fifth lumbar vertebrae and over left sciatic nerve, with advanced paralysis of entire right lower extremity. Abdominal, patellar and ankle reflexes normal and no evidence of sensory changes of the legs. A week later patient entered hospital. In the interval her right lower extremity had become completely paralyzed and there was some sensory loss of that part. The reflexes of both extremities were still normal but left sciatic pain increased and paralysis of that extremity had begun. X-rays showed some arthritis of lumbar region. Spinal fluid total protein reported as over 1000. Lipiodol showed complete block between twelfth dorsal and first lumbar bodies. Five days later she had complete paraplegia with sphincter control and reflexes lost. Operation by Dr. Tarlov 4/18/39 disclosed intramedullary glioma of the cord, inoperable and resistant to radiation. So far there is progressive return of sensation of both legs. Patient is being subjected to radiation.

**Case No. 10.** B. K., male, aged 54, told of severe twist of back in football game in 1903 followed by severe bouts of low-back pain and sciatica, continuing to increase in frequency and severity so that in the first three



Figure 7.

C. D. A. P. Roentgenogram shows complete block to Lipiodol at interspace between twelfth dorsal and first lumbar vertebral bodies. Film taken with patient on tilt-table set at 45° angle, head down.



Figure 8.

C. D. Lateral Roentgenogram shows complete block at level shown in Figure No. 7, with film taken in same position as that of Figure No. 7.

months of 1939 he had to be in bed much of the time. The routine treatments for sciatica applied by many surgeons failed to bring relief and resort to cultists also failed.

Examination revealed a peculiar element in the gait, as though from lack of confidence, decrease of normal lordosis, presence of definite lumbar spasm with acute localized tenderness over spines of fourth and fifth lumbar and first sacral vertebrae and left sciatic nerve: no atrophy normal reflexes and lowered sensitivity on lateral surface of left leg. X-ray showed marked arthritis on adjacent surfaces of fourth and fifth lumbar bodies with great loss of intervertebral space. Total protein reported normal. Lipiodol showed almost complete obstruction at level of fourth lumbar interspace. Operative removal 4/26/39 of extradural, friable, soft tissue allowed dura to expand into normal contour at that level and to assume normal color at and below that level. Patient allowed home on eighth day. Appears about ninety-nine per cent cured.

**Case No. 11.** M. S., male, aged 46, complaining of repeated attacks of low-back and sciatic pain during the last nine months to the extent that he had resorted to alcohol during those periods in an attempt to control the pain.

Examination showed insecure gait, some lumbar spasm, tenderness at lumbosacral joint, left ankle reflex absent, generalized weakness of left leg with much loss of light touch and sharp and dull perception. X-ray showed lumbar arthritis with some probable reduction of fourth lumbar interspace. Total protein reported normal. Lipiodol shows some filling defect at first and fourth lumbar interspace, the former being an almost complete obstruction. Patient has not yet decided in favor of operation

### Summary

1. Low-back pain with intractable sciatica may be caused by enlargement of ligamentum flavum or herniation of intervertebral discs, which we believe cannot be differentiated clinically.

2. Except when neurological signs definitely locate intraspinal stenosis, pre-operative recognition of such pathology is not made without the intradural use of x-ray contrast media.

3. Fluoroscopic examination on tilt-table is, in our belief, the most important single diagnostic procedure. Diagnostic photographic records are often impossible to obtain without spot-film attachments.

4. When indicated, the removal of Lipiodol may be accomplished with patient in sitting position by intradural insertion of a curved trocar through a drill-hole in sacrum.

5. Post-operative results to date show all patients now returned to their former occupations except two. One had an inoperable cord tumor and the other, who had been bedfast five years, is now pain free and walking with brace and crutches.

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### NUMBER PRACTICING RADIOLOGY HAS DOUBLED IN SEVEN YEARS Report By Bureau Of Medical Economics Indicates A Wider Availability Of X-Ray Facilities

The number of radiologists in the United States has more than doubled within the seven-year period ending in 1938, indicating a more widespread availability of radiologic services, according to a report by the Bureau of Medical Economics of the American Medical Association published in the Association's *Journal* for Sept. 2.

The report, prepared from data collected by the Inter-Society Committee for Radiology, states that in 1938 there were 2,191 physicians specializing in the use of x-rays and radium as compared to 1,005 in 1931. Consequently the population per radiologist of 122,614 in 1931 was reduced to 58,821 persons for each radiologist by 1938.

A trend towards an increase in the number of radiologists in communities with small populations is brought out by the study. In communities with less than 5,000 population there has been an increase from 28 radiologists in 1931 to 198 in 1938.

Analysis of the geographic distribution of radiologists shows that, while they are distributed in much the same manner as other specialists, there are proportionately more radiologists as compared with other specialists in the Middle Atlantic and Pacific states and proportionately fewer radiologists in the West North Central and East South Central states.

That the hospital is an integral part of the practice of radiology is indicated by the replies of those radiologists who returned questionnaires. Of 840 physicians, 802 stated that they were members of hospital staffs. Six hundred and twenty-three radiologists stated that they were heads of the department of radiology in the hospitals in which they practiced. However, 610 of the radiologists maintain private offices outside the hospitals.

—☆☆—

### CONGRESS ADJOURNS WITHOUT ACTING ON WAGNER HEALTH BILL

"The Seventy-Sixth Congress adjourned sine die Aug. 5 without acting on the Wagner Health Bill, S. 1620," *The Journal of the American Medical Association* for Aug. 12 states editorially.



## Blood Transfusions: A New Apparatus for Their Administration\*

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and

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There has been in recent years an increase in the use of blood transfusions. We propose at this time to present a simple apparatus for use in indirect transfusions.

It seems pertinent at this point to attempt to answer a question often asked and which may be in your minds; namely, why should anesthetists be concerned about methods for the transfusion of blood. All of us have, at one time or another, administered anesthetics for major surgical procedures during the course of which the problem has arisen as to whether the patient would be benefitted by transfusion. It is our belief that, whether the answer is in the affirmative or negative, the anesthetist must have a thorough understanding of the principles of blood transfusion to make his opinion worthwhile. Furthermore with the increased use of blood transfusion since the World War there has come the realization within many hospitals that there was no coordinated opinion as to indications, contraindications and method to be employed, to say nothing of lack of detailed records of the results and difficulties encountered. Executive officers of hospitals have recognized the fact that anesthetists, particularly in those hospitals where a part time or full time staff is employed, are constantly available. They are in position to supervise the maintenance of equipment, and their training qualifies them to undertake the responsibility for skillful venipuncture. It is for these reasons that departments of anesthesiology have undertaken the supervision of blood transfusions.

The American Board of Anesthesiology recognizes these developments within the specialty and anesthetists are well advised to put forth every effort to deserve the designation, "Anesthesiologists," an inclusive term indicating major

interest in anesthesia, gas therapy, resuscitation, intravenous therapy, and blood transfusion.

Bates<sup>2</sup>, Cogswell<sup>4</sup>, Jube<sup>5</sup>, Kempton, Brown<sup>5</sup>, and many others<sup>1,3,6,7,8,9,13,14,15</sup> have described methods which have involved various types of flasks, multiple syringes, and paraffin-coated tubes. In 1936 Walter<sup>16</sup> reported the development of apparatus for the preparation and administration of parenteral fluids. His apparatus for the intravenous administration of fluids was adopted at Hartford Hospital late in that year and a modified method for the preparation of solutions was developed. The system has been proven satisfactory and "intravenous reactions" have occurred very infrequently. It was realized however, that the apparatus was not applicable to blood transfusion, and an effort was made to develop a system whereby blood transfusions, administered by the indirect method, could be made through a closed system made up from the same equipment that was used for intravenous therapy.

Through the cooperation of the Macalaster Bicknell Company of Cambridge, Mass., a blood transfusion vent tube (fig. 1) was developed by means of which blood from the donor could be directed through sterile, citrated tubing into the flask containing 50 cc. of sodium citrate in 2.5 per cent concentration in sterile water. The central channel is used for this purpose. When the flask is inverted, the blood escapes through the outer channel. Details of the method are herewith described.

The donor is taken to the transfusion room and he is instructed to lie down on a stretcher. Both arms are inspected and the one which seems to present the most suitable antecubital vein is placed upon an arm board. The operator pre-

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TRANSFUSION VENT TUBE

Figure I.

The Blood is collected through the central channel. During administration, the blood enters the side arm through openings marked by the arrows.

pare the upper and lower arm of the donor and outlines the sterile area by means of sterile towels. A tourniquet which is part of the sterile equipment is placed in position and tightened by means of a hemostatic clamp. An intradermal wheal is raised with 1 per cent novocaine directly over the proposed site of puncture. A sterile graduated pyrex flask is equipped with a one-holed rubber stopper through which the transfusion vent tube is inserted. To the central channel a delivery tube, 10 inches in length, is attached. The distal end is fitted with a glass adapter which in turn fits the needle through which the blood is obtained from the donor. The outer channel is equipped with a rubber tube through which a negative pressure may be created in the flask by means of a suction bulb. An ampule containing 50 cc. of 2.5% solution of



Figure II.

Collection of the blood from the donor.

sodium citrate is opened and the needle is placed in the fluid. By means of pressure on the bulb, the sodium citrate is drawn through the needle, tubing, vent tube, and finally into the flask. The flask is then set on a stool, two feet in height, which is covered with a sterile towel. The tourniquet having been tightened sufficiently to distend the veins, the operator then draws the skin wheal laterally and punctures the skin through the wheal without danger of transfixing the vein. Once the needle is through the skin the wheal is allowed to return to its former position over the vein and the venipuncture is performed. As the blood flows, the operator slowly agitates the flask (fig. 2). When the desired amount has been obtained, the needle is withdrawn from the vein and a firm pressure bandage is applied to the site of puncture. The donor is requested to lie quietly for at least one half hour. The flask containing the blood is then placed on the sterile tray and both tubes are removed from the vent tube. A ten-inch sterile rubber tube about which there is a screw clamp is then attached to the side arm of the vent tube. A sterile glass cap is then placed over the arms of the vent tube, fitting snugly on the rubber stopper. The blood can then be taken to the patient's room (fig. 3).

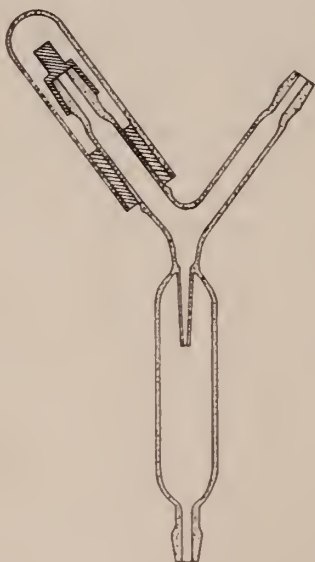
A saline infusion is started. The distinguishing feature of the intravenous set is a Y tube into which is incorporated a Murphy drip (fig. 4). One arm of the Y is attached to the tubing from the saline flask. The end of the other arm is covered by a snugly fitting rubber cap (fig. 4).





Figure III.

Collected blood ready for transportation to the patient's room.



Y WITH MURPHY DRIP

Figure IV.

The delivery tube from the flask containing blood is attached to the Y after the outer glass cover is removed from the rubber collar and the glass cap is removed from the end of the side arm.

Over the entire arm there is a glass cap which fits snugly to a rubber collar at the base of the arm. An assistant removes the glass cap from the arm of the Y tube and the glass cover from the flask. The operator then tightens the screw clamp which is about the tubing attached to the side arm of the vent tube, inverts the flask, and places it in a carrier which is suspended at a point several inches below that of the flask containing saline. The small rubber cap over the end of the arm of the Y is removed, and the tubing from the flask containing blood is attached (fig.5). With this arrangement one may allow either blood or saline to flow. One may also permit both saline and blood to flow, providing the rate of flow of saline is kept very slow. One may dilute the blood with saline in those instances where one is forced to employ a needle of small calibre. In the event that a patient is to receive only a fraction of the blood at this particular time, the needle is removed from the patient's vein, the flask containing the blood placed upright, and the tube is removed. A

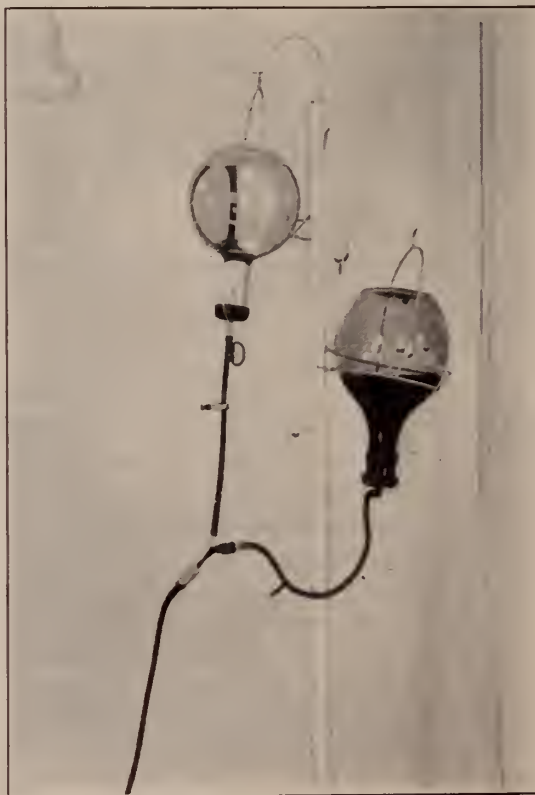


Figure V.

The complete system during administration of the blood.

sterile glass cap is set on the rubber stopper. The flask is then placed in the refrigerator which should be kept at 4°C.

Experience in over 1,000 transfusions has proved that this equipment is efficient and practical. It has been found that it is possible to deliver 500 cc. of blood in 30 minutes. By means of Lundy's<sup>12</sup> hand-roller whose action is similar to that of milking the tubing, 500 cc. of blood may be delivered in 5 minutes. In order to hasten the rate of flow during the course of a surgical procedure one may attach a blood pressure bulb to the central channel of the vent tube and create a positive pressure above the blood as suggested by Hedin and Karp<sup>11</sup>. The system lends itself admirably to Keckwick and Marriott's<sup>10</sup> continuous drip transfusion which has as its purpose restoration of the hemoglobin to its lower limits of normality. This system can be used for infants and children.

We have described a practical and efficient method for the administration of blood in a closed system as proved by its use in over 1,000 transfusions. This method is an adaptation of Walter's original method of administering intravenous fluids which permits use of the equipment, that he described, for blood transfusions.

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*Jour. Mich. State Med. Soc., June 1939*

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## Political Therapeutics†

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Therapeutics is the name given to that branch of medicine dealing with the means employed to prevent or cure disease or to lessen its evil results when a cure is out of the question. What a blessing it would be if this science could be developed to deal with the afflictions of the body politic! These afflictions are numerous and they result not infrequently in dire consequences. Prevention, the ideal aim of medicine, has greatly advanced in recent years and reformers have attempted to apply preventive methods in the sphere of political action. For the most part they have not succeeded well, due largely to their tremendous capacity for faulty diagnosis. We have an instance of this in the Seventeenth Amendment to the Constitution, which provides for the direct election of United States Senators.

There had been occasions where corruption had crept into the election of Senators by legislative bodies and somebody conceived the idea that this could be prevented by a popular primary followed by a popular election. A vast propaganda was carried on to bring about this change. Those who opposed it were branded as reactionaries, more desirous of serving selfish interests than contributing to the general welfare. They were represented as creatures of darkness, preferring the ways of evil to those of good, and when the debate had worn itself out they found themselves in the minority.

So for the last twenty-six years our United States Senators have been chosen by the electorate at large, instead of by the method originally provided for under the Constitution. But no one can say with truth that the calibre of Senators has improved, that they exhibit a higher degree of statesmanship than was shown by the Senators of old, that their elections have invariably been free of taint, that money and political manipulation have not played their

accustomed parts, that appeals to passion and prejudice have been eliminated, and that the practice of the demagogic art has not succeeded in winning for some a place in the Senate. In making this departure from the representative principle of our government nothing whatever has been gained and much has been lost. If the Legislature was not to be trusted to choose a Senator wisely, whose fault was it but the indifference of the people themselves to their choice of the members of that body? It is lack of attention to the concerns of our own local politics that gives rise to the evils we complain of in state and national government.

Another and more easily understood instance of faulty diagnosis is to be found in the hasty adoption of the Eighteenth Amendment, which plagued us for thirteen years. Its proponents argued with a fair show of plausibility that if prohibitions against liquor were written into the Constitution we should have in no time at all a state of national sobriety that would make our nation the envy of the world. They saw none of the concomitant evils that were soon to flow from this attempt to make total abstinence compulsory, and their dream of a generation that would grow up without knowledge of alcohol was soon dissipated. The political doctors found that they had a rebellious patient on their hands who could not be cured by allopathic doses of Volsteadism. It was also found that the laws of fermentation could not be set aside either by a constitutional mandate or an act of Congress. To get the offending amendment out of our fundamental law was more difficult than to get it in, but out it eventually went and with a suddenness that revealed that never had there existed any real desire on the part of the people to put themselves in a strait-jacket.

One could go on almost indefinitely enumerating the failures of political nostrums to work

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\*Editor, The Hartford Courant.

their cure, but this should not be surprising to the members of the medical profession. They too have had their moments of bitter disappointment over the failure of therapeutic agencies to come up to expectations. Whether the treatment be symptomatic or radical, empirical or rational it leaves much to the element of chance. So it is in politics, only in this field little seems to have been learned from the blunders of the past.

At the moment this world of ours, the old and the new, is desperately sick and there is a wide disagreement among the political doctors as to the remedies that should be employed to promote physical recovery and restore moral values. The sickness is the lingering kind, setting in ten years ago with only occasional improvements in the patient's condition, followed by alarming relapses. The primary cause is directly traceable to the World War, which took toll of 23,000,000 lives, besides accounting for an equal number of casualties, and leaving 9,000,000 orphaned. Among those killed or disabled for life were many who were capable by their natural endowments of making great contributions to the civilization and progress of mankind.

In money this World War cost the participating nations close to 350 billions. Of this staggering sum, far too great for the human mind to comprehend, 32 billions fell upon the United States during the period of the war. The continuing costs to this country now total nearly 20 billions more, making a grand total of 52 billions as the contribution we made in money alone to make the world "safe for democracy." It is now apparent that the venture in that respect was a total failure. Dictatorial governments, wielding tremendous power, have sprung up in most of the democracies created by the Treaty of Versailles.

Those who would assign the cause or causes of the economic depression that befell this and all other so-called civilized nations nearly a decade ago have only to look to the World War to ascertain the real cause. Its destruction of millions of lives and billions of accumulated capital could not but result otherwise than in producing the conditions we now have. Economic laws work with especial severity under such circumstances and in trying to combat or

circumvent them a wide variety of nostrums have been employed. Some of these nostrums were tried and found wanting hundreds of years ago, yet they have been proclaimed as new discoveries. In general they substitute an economy of scarcity for an economy of plenty. They stifle individual initiative and private enterprise. They stop the flow of capital into productive business. They employ taxation for punitive purposes. They pile debt upon debt in the absurd belief that by "investing in deficits" we shall increase the national income and restore prosperity. They impose all manner of restrictive laws, tinker with currencies, borrow from Peter to pay Paul, subsidize the inefficient at the expense of the efficient and ignore the teachings of the past.

For the last six years America has been called upon to endure no end of costly experimentation. Our political doctors have run up for future generations to pay a bill of twenty billion dollars. They will have succeeded by the close of the next fiscal year in bringing the national debt up to the astronomical figure of 45 billion dollars. Although by resorting to burdensome taxation they have brought to the Federal Treasury a greater revenue than it has ever before known, they have so increased the costs of government as to produce a constantly growing deficit. They are spending at the rate of \$15,000 every minute as against the \$8000 that comes in. They are thus putting us \$7000 in the hole every minute, yet they wonder what is holding recovery back. The individual knows that he cannot improve his economic status by borrowing and spending, any more than he can drink himself sober. Government cannot perform these feats of magic upon itself. It represents nothing more than an aggregation of individuals. It has no money whatsoever of its own. What it gets it derives from the people through taxation. What it borrows comes from the accumulated savings of these same people.

The public seems to be largely indifferent to the huge deficits that are being piled up at Washington. From them it sees no immediate bad effects, but it should not be overlooked that the carrying charges on the national debt now amount to a billion dollars a year. It may help that sum to register in the popular mind if it is re-



alized that it would take more than nineteen hundred years to spend a billion dollars at the rate of one dollar a minute. The budget is now so far out of balance that it cannot possibly be balanced for years to come, and the temptation will be increasingly greater to resort to inflation or take refuge in repudiation, with all the disastrous consequences that either course entails.

At the beginning of this Congress there was reason to believe that the Senate, at least, would attempt to practice economy, and in small ways it has done so, yet we have only recently witnessed the spectacle of that body increasing the House appropriation for the Department of Agriculture by nearly four hundred billion dollars, bringing the total for this one department alone to nearly a billion and a quarter, a sum in excess of the cost of running the entire federal establishment in the year just before we entered the World War. Subsidies and bounties of one sort and another seem the order of the day. Extravagant political methods to care for the unemployed employables have a natural tendency to increase the relief rolls. The theory of Grover Cleveland that though it is the duty of the people to support the government it is not the duty of the government to support the people has been almost completely reversed.

We prate about our democracy in seeming ignorance of the fact that our forefathers set up here not a democracy but a republican form of government of checks and balances. We denounce the methods of totalitarian states with the complete subserviency they impose upon the individual, yet little by little we permit the Federal Government to enroach more and more on those rights and liberties of the citizen that are supposed to be a part of our great heritage. We see the States losing their autonomy as the Federal Government takes over the duties and obligations that were once theirs. Centralized control from Washington is becoming almost

daily more evident. We are told when to sow and when to reap, forgetting that Jefferson admonished us that under such a policy we would soon lack bread. Price-fixing, once legislated against when practiced by private agencies, has become an accepted device for government to employ. It was not so long ago that we sent the proprietor of a little tailoring establishment to jail for pressing a pair of trousers for less than the price fixed under the Blue Eagle.

We have seen the attempt made to influence judicial decisions by packing the Supreme Court and thus to make the judicial branch subservient to the will of Congress and the Executive. We have seen a National Labor Relations Board created that exercises at one and the same time the functions of prosecutor, jury and judge. We have seen social security funds used to defray the current expenses of the government. We have seen the interstate commerce clause of the Constitution so stretched as to permit almost every economic and social objective, whether sound or not. We have seen the farmer subjected to a degree of regimentation against which he would have fought had not his individualism been crushed by a long continuation of political exploitation. We have seen him told that it would be unconstitutional to restrict the size of his crops, but that it is entirely constitutional for the government to limit the amount he can sell. All these things are going on in the name of democracy, but they bear a close resemblance to the practice of totalitarian governments.

Is there, after all, a surer way to maintain the virtues of our representative democracy, of our republican form of government, than by holding fast to the principles of the Founding Fathers under which the lot of the average man in America has been the envy of the world? Let the medical profession help us to evolve a system of political therapeutics that will do for the body politic what it is so successfully doing for the individuals who compose that body.

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# State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

## The State Department of Health Maternal Care Program

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During recent years there has been extensive development in the activities related to maternal care, and in the attitude of both the medical profession and the public toward the prevention of maternal mortality and maternal morbidity. Since the time of its establishment in 1919 in the Connecticut State Department of Health, the Bureau of Child Hygiene has cooperated with the medical profession in carrying on health educational work with mothers.

Education of the public regarding health is one of the most important functions of the physician. It is his obligation to take the lead in community instruction in the hygiene of healthful living and in the prevention of disease.

Better medical care for all members of society is the objective of the present day physicians. This objective is possible only if the public is educated to use extensively and wisely the facilities already in existence, rather than to establish new services which might introduce politics and bureaucracy into the care of the sick.

Connecticut compares favorably with surrounding states in strict requirements for licensure to practice medicine, in the percentage of hospital deliveries, and in the percentage of deliveries attended by physicians. No doubt there are other less tangible factors which have had an influence in reducing the maternal mortality rate in this State. The following table shows maternal mortality rates for several nearby states.

### Maternal Mortality Rates — of Certain States Per 1,000 Live Births

	1935	1936	1937	1938
Connecticut . . . . .	4.3	4.1	2.8	2.9*
Massachusetts . . . . .	5.7	4.9	4.6	
New Hampshire . . . . .	6.1	4.8	4.5	
New Jersey . . . . .	4.6	4.0	3.8	
New York . . . . .	5.3	4.9	4.0	3.6*
Pennsylvania . . . . .	5.5	5.2	4.8	
Rhode Island . . . . .	4.4	4.0	3.8	

\*Provisional

From the following table it will be noted that Connecticut had a higher percentage of hospital deliveries attended by physicians in both 1935 and 1936, as compared with surrounding states.

Connecticut has a higher percentage of deliveries attended by physicians than has any other state in the country; and a higher percentage of these deliveries occur in hospitals.

The facilities in maternity hospitals may, in a large part, determine the ease with which good medical care is rendered maternity patients. The principles of asepsis and certain fundamentals of nursing care for the patient should be provided for. With more and more women being delivered in hospitals, it is increasingly important from two points of view that they be safeguarded against infection and other avoidable complications. First — from the point of view that maternity hospitals designed for the care of a few patients are now confronted with the prob-

\*Director, Bureau of Child Hygiene.



**Live Births Attended by Physician  
(Record for Certain States)**

	1935			1936		
	Total	Physician in hospital Per cent	Physician not in hospital Per cent	Total	Physician in hospital Per cent	Physician not in hospital Per cent
United States . . . . .	2,155,105	36.9	50.6	2,144,790	40.9	47.3
Connecticut . . . . .	22,258	74.5	23.7	22,228	78.9	19.2
Massachusetts . . . . .	63,001	59.5	3.9	61,703	72.6	5.9
New Hampshire . . . . .	7,768	30.6	69.1	7,679	29.6	70.1
New Jersey . . . . .	54,514	65.2	28.1	53,833	69.8	24.3
New York . . . . .	184,344	73.6	23.8	182,469	76.7	21.1
Pennsylvania . . . . .	161,166	41.3	57.6	159,373	45.6	53.1
Rhode Island . . . . .	10,215	59.8	38.3	10,186	62.8	35.0

lem of crowded conditions and inadequate nursing services, and second — from the point of view that the health of more mothers and new born infants is endangered under these conditions. Centralizing the care of maternity cases in hospitals makes it necessary that strict techniques be followed to prevent cross-infection. Certainly every safeguard should be made to prevent infections because of certain advantages of hospital care at the time of delivery.

The supervision of midwives is carried out by a public health physician of the State Department of Health and all new candidates for midwifery licenses must pass an examination before the midwifery board which is composed of three physicians. The number of midwives registered to practice is declining year by year in Connecticut. In 1937 there were sixty-eight midwives who were listed as being in active practice, and the number of cases delivered by them was only 385. These small numbers indicate that a very small proportion of maternity work is being done by midwives and this is with foreign groups.

The State Department of Health employs as supervising public health nurses — graduate nurses who have had a one year course and two years of experience in public health nursing. (As in other public health positions, where personnel are expected to have special public health training, the public health nursing positions must be filled by fully trained personnel.) The supervising public health nurses on the staff of the Bureau of Child Hygiene carry on educational work with

expectant mothers through home visits and Mothers' Clubs in rural areas.

The public health nurse calls on an expectant mother to encourage her to register with her physician for prenatal care if she has not already done so. When the mother is registered with her physician the nurse reports to him for his orders. If he wishes her to continue calling on the patient she can assist by teaching the mother fundamentals of maternal hygiene and how these can best be carried out in her particular home. She also assists him by reporting home conditions and the environment surrounding the patient. In instances where adequate food is not available, the public health nurse may contact welfare agencies in order that the mother may have an adequate diet. At all times the public health nurse is expected to serve as a teacher and helper and to carry out special orders of the attending physician. Because many cases proceed normally, it often seems unnecessary to expectant mothers to seek prenatal medical care. The public health nurse in a tactful way must be instrumental in making patients realize the full value and safeguards achieved by securing medical care throughout their expectant periods.

It has been found that with proper instruction of patients, more prenatal care is sought in the office of the attending physician. The following table gives information indicating an increase in prenatal care in Windham County following an extensive educational program by public health nurses.

### Month of Expectancy At Which Mothers Sought Medical Care

Survey—March, April,  
May, June 1936

Survey—February,  
March, April 1936

<i>Month of Pregnancy</i>	<i>No. Patients</i>	<i>Per cent</i>		<i>No. Patients</i>	<i>Per cent</i>	
1	8	4.	} 59%	41	25.8	} 64.8%
2	52	25.		25	15.7	
3	39	18.		23	14.5	
4	25	12.		14	8.8	
5	20	9.	} 32%	12	7.5	} 29.9%
6	15	7.		13	8.1	
7	16	8.		12	7.5	
8	14	7.		5	3.1	
9	3	1.		6	3.7	
Del.	19	9.	} 9%	8	5.	} 5%

During the interval, there has been a definite increase in the number of women who have sought medical care early in pregnancy. It is also evident that there is a gradual reduction in the number of women who failed to consult their physicians until after the fifth month of pregnancy as well as those who waited until the onset of labor. Since the women in this area have suffered financially from poor industrial conditions during the past year, it would seem probable that the improvement in maternal care during a period of economic depression must be accounted for by the nursing program and the beneficial effect from educating expectant mothers as to the necessity and value of medical and nursing care during the period of pregnancy.

In places which are distant from hospitals it is difficult for patients to have hospital care due to poor transportation facilities and due to lack of money. In such places assistance in the way of sterilized linen and the help of graduate nurses at home deliveries is desirable. Wherever physicians feel the need of better equipment in the way of sterilized linen at home deliveries, the State Department of Health helps local women's groups to make obstetrical packages, the contents of which can be sterilized at nearby hospitals. In many communities in the north-

eastern part of the State these packages are in use.

"The rich and the poor receive good medical care" but middle economic groups do not. The need for proper medical care for all persons and the difficulty which the middle economic groups find in securing medical care have resulted in discussion and presentation of many different socialized medical programs for the solution of this problem. That the quality of medical care depends upon the desire of patients to receive it and upon the individual physician selected seems true. Laboring men paid a small weekly wage can provide for their families the bare necessities of life and perhaps can set aside a small amount of money toward an expected confinement but if some abnormal condition appears during the expectant period there are no financial resources from which to draw for needed obstetrical consultation. It is for patients of this economic level that the obstetrical consultants have agreed to give consultation when requested by the attending physician. With the recommendation of consultants by the Connecticut State Medical Society the State Department of Health is cooperating by paying a small consultation fee for problem maternity cases living in any town except Bridgeport, Hartford, New Britain, New Haven, and Waterbury.

Distribution of educational literature is one of the effective methods of instructing expectant mothers. Upon request of public health nurses or individual women, a series of prenatal letters is sent during the expectant period at monthly intervals. This has been found to be a helpful method of giving information and stimulating women to seek medical care throughout their pregnancies.

The following points indicate the instruction which is given through literature and by public health nurses in regard to maternal care:

1. Every young man and woman should have a premarital examination to determine their fitness for marriage and parenthood.
2. Every expectant mother should be under the care of a competent physician from the very beginning of pregnancy and should remain under medical supervision throughout the entire period. She should visit the physician at least every month

(Concluded on Page 588)



# The JOURNAL of The Connecticut State Medical Society

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**MANUSCRIPTS.**— Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

**ILLUSTRATIONS** — Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

**NEWS.**— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

**ADVERTISEMENTS.**— All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

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## • Editorials •

### WHO CARES ABOUT THE ANNUAL MEETING PROGRAM?

Answering questionnaires is a bore and one often wonders who compiles statistics after the returns are received. Amazingly enough the returns from the inquiry in regard to the last State Meeting, together with suggestions for forthcoming State Meetings, provided considerable interest and novelty.

In the first place, half the membership of the Society replied and these replies were about equally divided between people who were present at the meeting and people who did not attend. Two of the questions asked were of paramount interest to the Program Committee. First, were the people who came satisfied? To this question an overwhelming affirmative was given; but 45 were disappointed in the meeting after they came. All shades of criticism existed in individual instances. The same mail contained complimentary comments about the Hotel as a meeting place from one individual and severe criticism of the acoustics, public address system and ventilation from another individual.

The second most important opinion in the eyes of the Program Committee was why the members who stayed away did not appear. Only 47 of these 400 absentees who replied did not attend the meeting because they found nothing of interest in the program to attract them. Apparently to 92 out of 800, the program was not satisfying; 116 members of the Society offered to cooperate with the Program Committee but several of them forgot to append their names.

The Program Committee desires to express their gratitude for the time and effort spent in answering the questionnaire and for the many constructive suggestions offered. If these suggestions can be classified, a few general deductions might prove interesting:

- a. That more subjects of interest to the general practitioner in meeting his daily trials should be included (17 comments). This despite the fact that even the section papers were designed to present the or-

dinary crises to be met by the general practitioner. Certainly, burns, pneumonia, painful periods, forcep deliveries, etc., are everyday problems.

- b. It is assured that the section meetings will continue in the afternoon.
- c. There appears to be a desire to divide the Ophthalmological Section from the Otolaryngological Section.
- d. A certain amount of logical reasoning should be applied to the whole subject of section meetings. There seemed to be an impression among a few that section meetings were for specialists only. When, as a matter of fact, the subdivision offers opportunity for a wider variety of subjects and more intimate practical discussion. As an example of the diversity of impression, some men commented "the general practitioner had no place to spend the afternoon". At the same time, other general practitioners complained that subjects of interest to them were being discussed simultaneously and they "regretted they could not be in two places at once."

The usual number of criticisms of "too much theory," "not enough of interest to the general practitioner;" "too many professors;" "too much text book," were received. It appears, that a large number of practitioners desire that specific therapeutic measures be offered them. The only specific therapy recently developed includes sulphanilimide and sulphapyridine. The use of these drugs should be surrounded by caution and require observation of the blood count, discrimination in use depending on the type of bacteria, measurement of the drug content in the body fluids, etc. As soon as these restrictions are explained in a paper and the practitioner is required to use some thought and care in the administration of the drug, he says that it is "theory;" complains of the "professional attitude." At the same time he is being cautioned for the benefit of his patient.

Great care must be exercised by the Program Committee for the State Medical Society and the Program Committee for the Clinical Congress to see that these two organizations function successfully and that the fields shall not overlap. We conceive of the two as being supplemental: — The Clinical Congress an intensive three-

day post-graduate course in Medicine, and the Annual State Medical Meeting, an opportunity for organized Medicine to discuss questions of common interest, i. e., ordinary crises in general practice, questions of public health, the present status of socialized medicine, together with a certain amount of opportunity for social hours.

The opinions expressed concerning the commercial exhibits that have been held in connection with the Annual Meetings for the past three years were almost unanimously favorable. Only sixteen of the 639 members who replied thought that the Meeting would be improved if the exhibit was omitted. From a financial standpoint the exhibit is an important part of the Meeting for the proceeds from it more than pay all of the expenses of the Meeting. If it continues to be a successful enterprise for the Society, the members must realize that they should visit and register at the exhibitors' booths, otherwise these commercial houses will be unwilling to participate in the exhibit and pay the necessarily high cost for space. Some comment was made in the replies with respect to exhibits by publishers of medical books. For some reason or other that is not well understood by the management of the exhibit, it has been next to impossible to interest medical publishers in taking part in the exhibit. It would appear that here was an unusual opportunity to interest prospective book buyers in a publishers' current offerings, and now that such exhibits have been asked for by our members it is hoped that some publishers may be attracted.

If the commercial exhibit is to be continued it must be patronized.

A. N. C.



#### NEGLIGENCE, FEAR AND IGNORANCE

At the last Annual Meeting of the State Medical Society held in New Haven in May of this year one of our own members, Doctor Edward J. Ottenheimer of Willimantic, presented the subject of "Delay in Recognition of Surgical Conditions." In this paper Doctor Ottenheimer called attention to the delay of over one year in the hospitalization of cancer patients after appearance of the first symptom, as reported by Doctor Brae Rafferty in the March 1939 issue of the Journal. He also called attention to the delay of more than four years in admission of cases of benign prostatic hypertrophy to the



Windham Community Hospital, of over three years in cases of peptic ulcer and of slightly less than four years in cases of gall bladder disease. Doctor Rafferty's report ascribes to negligence, fear and ignorance on the part of the patient about 58% of the delay, to poor medical advice 22%, a total of 80% remedial by education. To quote Doctor Ottenheimer, "it is my distinct impression and opinion that these figures, if data were available, would also closely approximate the reasons for delay in conditions other than cancer."

The implications in such a statement are significant. If the medical profession and, in particular, the Connecticut State Medical Society are to reduce morbidity and mortality in the fields of medicine and surgery there is much to be done in preventive medicine. Educating the public is being carried out today by lay organizations and by business firms on a large scale through press, radio and platform. Our own State Medical Society has an opportunity which should not be neglected. True, the individual physician can and should emphasize to his patients the necessity of heeding first symptoms. Through a regular annual follow-up of his patients he may be instrumental in detecting incipient disease, but how many of our members do have such a follow-up system? How many of us still do not hesitate to urge our patients to return to us regularly for examination?

A few years ago one of our County Associations formed a Medical Information Bureau, designed to improve relationship between profession and press, to extend and improve radio broadcasting of medical subjects and to supply lay groups with competent speakers in the field of medicine. The Bureau has justified its existence, but in one field, namely, its relations with the press, only the surface has been scratched. As yet no other County Association has seen fit to put in operation such a bureau.

At the Annual Meeting of our State Medical Society in 1938 the House of Delegates approved the formation of a Committee on Public Relations. The scope of this committee's endeavors is almost limitless. To educate the public should be one of its first projects. If 80% of the delay in hospitalization of the common surgical conditions as well as 80% delay in hospitalization of cancer patients exists within our own State today we have an opportunity at hand as well as

an obligation to meet. Our own hospital records should afford us information as to the estimated delay following the appearance of the first symptom and the reason for this delay.

In New Jersey and Michigan the lay press is being extensively utilized by the respective State Medical Societies for purposes of medical education. Herein lies a most important field for reaching the public. The newspaper man, be he editor or reporter, is not such a bad fellow, in fact, he is a valuable friend and his friendship should be carefully cultivated to the mutual advantage of both physician and writer. The press in every town and city of Connecticut boasting a news sheet should be regularly utilized by our Committee on Public Relations for dissemination of medical information. The radio through every broadcasting station in Connecticut should carry regular medical programs of an informative nature, if for no better reason than to counteract much of the ballyhoo of commercial firms permitted throughout our land. More and more of our members qualified with a natural ability to speak from the platform should be using this gift in the interest of preventive medicine. 80% delay due to negligence, fear and ignorance on the part of the patient, plus poor medical advice, is too high a percentage to be allowed to stand without a challenge from every practicing physician.

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## TWENTY FIVE PERCENT DISCOUNT

The campaign for a wide and costly program of government medicine came to a temporary halt with the adjournment of Congress, and in the quiet before another engagement, thoughtful taxpayers may well take time for a realistic analysis of the proposals. Whether or not there is a need for widespread Government participation in medical care is a subject for debate and divergence of opinion, and there is likewise uncertainty in the minds of many concerning the quality of care that would be provided. Argument on these two subjects may never end, but there is little question of the cost. Even with a comparatively modest beginning the funds asked for were large, and it is admitted that the necessary appropriations would mount with the years.

In Government activity of any kind there is always the item of "administration," and the

money provided for it is not always so clearly separated from productive funds that the running taxpayer may read and understand. The National Economic League, a non partisan institution, devoted to the study of Federal expenditures, has lately published figures concerning the spending of money appropriated for relief. In 1938 one billion dollars of relief funds never fed hungry mouth or sheltered a destitute head, but went to administration and expense and helped to support the army of nearly four million office holders. It was more than twenty-five percent of the total funds appropriated for relief.

The addition of the medical care project will carry with it another huge administrative load, and money spent in the bureaucracy will cool no fevered brow or heal a broken limb.

C. B.



### HEALTH EXAMINATIONS IN RELATION TO CANCER

It is practically axiomatic that the earlier in the disease a diagnosis of cancer is made and proper treatment instituted, the greater is the possibility of a cure. Another truism about most types of cancer is that it has few or no obvious early symptoms. Accepting the premise then, that in order to cure cancer prompt treatment is necessary and that the disease shows few if any obvious early signs, it would seem on casual study that not very much could be done to improve the situation.

For all our increasing success in preventing, controlling and curing the disease, a continued increase in cancer morbidity and mortality may be expected for some time to come. But we know that this increase in cancer deaths is due largely to an increase in the average age of our population and to more accurate diagnosis of the disease and little to an actual increase in the disease itself. Thanks to better sanitation, improvement in methods of preventing deaths from acute infections, and general betterment of our environment, the average age of our population has doubled. Obviously this increase adds many to the number who come within the cancer age group.

It is quite possible that this factor alone may make it difficult to bring about any lessening in the cancer death rate until a level population age is reached. It is hard to dam a river when

it is in flood and constantly being fed by heavy rains and melting snows.

Nevertheless, a great deal can be done even in the face of apparently insurmountable difficulties, and much has been accomplished in this state during the past few years to mitigate the suffering of those afflicted with cancer.

As a result of the efforts of the tumor committee of the State Medical Society, facilities for the treatment of cancer in Connecticut are now numerically sufficient, and adequately staffed and equipped in practically all cases. The cancer patient in this state may now expect to receive treatment that will produce results comparable with those to be found in any community.

That the fullest advantage may accrue from the facilities available, it is necessary that more cancer cases be treated at an early enough stage of the disease to admit a chance of cure.

One way in which the medical profession can help to bring about this desideratum is by doing more periodical health examinations. It may be that the number of cancer cases discovered at the health examination will be small but the fact remains that one cancer discovered in its first stages and cured, can and will result in a great deal of lasting benefit to patient and physician. There is little question that the patient's life has been saved, and the doctor has the satisfaction of having done a bit of work well worth while, if nothing more material eventuates. The periodical health examination presents the physician with an excellent opportunity to give the patient some wholesome advice about cancer, and the importance of consulting a doctor immediately should signs present themselves during the period between examinations. And probably of as much importance, the doctor can so present the subject that the patient does not leave his office in a blue funk over cancer, but in a frame of mind which will permit him to look at the situation sanely and to act with sagacity.

It goes without saying that many abnormal conditions other than cancer may be found in the course of the health examination. In fact, the probabilities are that many more cases of heart disease, diabetes and other ailments will be found than malignancies.

As a means of clinical study of a large number of individuals, with particular regard to the mode of onset and possibly the etiology of the de-



generative diseases, the health examination should be useful. After all, just when does malignant change take place in cases of cancer of the breast? Fitz\* in a recent article, notes several cases of cancer in different organs in which symptoms appeared within sixty days or less after a detailed health examination had showed nothing abnormal. Why is it that occasionally a patient who has repeatedly been found apparently normal upon careful examination suddenly succumbs to coronary disease? Is the onset of diabetes always insidious, or does it develop suddenly? Answers to these and many other questions may possibly be found in the data to be obtained through the careful examination of many individuals.

M. H. G.

\*Fitz, Reginald, M.D., *The Periodical Health Examination as a Method of Clinical Investigation*; J.A.M.A. 112; 1115-1120 (March 25) 1939.



## PROPOSALS FROM THE COMMITTEE OF PHYSICIANS

During the past summer the Committee of Physicians for the Improvement of Medical Care, Inc., issued an appeal for contributions to carry it through the coming year. With many of the principles for which this committee has stood we have no quarrel; some of its methods have not been above criticism. The Secretary of the Committee states that expenses during the past year have amounted to about \$2500.00. No inkling of just what further contributions will be used for is offered, except that further activities are contemplated. Signators of the Committee are encouraged to supply "remarks; favorable or otherwise," as well as "suggestions for further activities."

With this plea for funds were issued several specific proposals for amendment of the Wagner Bill (S.1620). The outstanding proposal of the Committee is that there shall be a General Health Council "which shall have the power to define and supervise standards of medical education, research and care whenever it is proposed to make Federal Grants-in-aid and these shall not be made without its approval." This General Health Council would have its chairman and executive officer the Surgeon General of the U. S. Public Health Service and would be com-

posed of eight more persons, a majority of them holding degrees of Doctor of Medicine. All this is predicated on the principle that good medical care is not available to a large portion of the population of the United States. The soundness of this principle appears still to be in doubt if one reviews carefully the result of the recent study made by the American Medical Association.

The Committee of Physicians for the Improvement of Medical Care, Inc., would seem to be making an honest effort to aid the Federal Government and Mr. Wagner to make the Wagner Bill more acceptable to the medical profession. This fact is very apparent to any one who will carefully read Senate Subcommittee Report (No. 1139) on Establishing a National Health Program. Legislation for a national health program will re-appear in the next regular session of Congress, whether in the form of amendments to the present Wagner Bill or clothed in an entirely new bill. Apparently the Senate Sub-committee to whom this bill has been referred, as a result of numerous hearings, realizes many of the bad features of the bill as well as many of its shortcomings and is preparing itself to correct these.

One specific proposal of the Committee of Physicians calls for a consolidated State Health Council for each state to facilitate the several services provided under the bill. Even though consolidation and unification of health services is the aim, the existing Departments of Health in each State are passed by for another and new organization.

The Committee of Physicians and the Senate Subcommittee both recognize the wisdom of organized medicine's criticism of the proposal in the Wagner Bill to establish new hospitals and health centers irrespective of available empty beds in public and private institutions now in existence. Such construction, they now advise us, should be carried out only where existing facilities are inadequate.

The Committee of Physicians recognize that there is an unwillingness on the part of many individuals to submit themselves, unless seriously ill, to medical care but no solution is offered to combat the ignorance which accounts for much of the morbidity and mortality. If a national health program is to be effective it is no secret that many more physicians must be

trained to properly carry out such a program and with this end in view opportunities for initial training and continuous education of physicians must be increased. Today we have far too few qualified to carry out such an extensive program as is contemplated.

The people of the United States not yet have been sold on the manner in which the Social Security Act is now administered. To pattern the administration of Grants-in-aid for health measures on those now existing in the Social Security Act will not received universal approval.

The Senate Subcommittee proposes that there be an additional title (XV) to the Wagner Act to better safeguard and improve the health of industrial workers and for strengthening the administration of workmen's compensation laws in the States. This is a decided step in the right direction.

Whether or not you are a Signator of the Committee of Physicians their proposals for changes in the Wagner Bill merit your careful consideration. To be ignorant of impending legislation of such vital concern to the medical profession is to be guilty of that greatest of sins of which we as physicians have been accused, namely, indifference.

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#### ADVERTISERS IN THE JOURNAL FOR 1940

To hold our present advertisers for the coming year we must satisfy them that we are interested in their products. Several by the use of coupons and literature offer to supply more information to our readers. We urge all to show their interest by replying to such advertisements during the remainder of 1939. The burden the State Medical Society assumes in maintaining the Journal is materially lightened by our advertisers. Our Journal has made an excellent showing in its advertising during the three years it has been in existence. We bespeak your hearty support.

#### GAYLORD FARM CLOSES NEW HAVEN OFFICE

After September 1st the New Haven examining office of the Sanatorium will be discontinued. All applicants for the Sanatorium will be seen at the Sanatorium by appointment (telephone Wallingford 1350 during business hours) or considered on the basis of a full medical report and recent x-ray film.

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#### LEGISLATION PROVIDING FOR A FOUR YEAR MEDICAL SCHOOL IN ALABAMA

A committee of alumni of the University of Alabama have reported in favor of expanding the present two year medical school to the status of a four year medical school. The various county medical societies throughout the state will be asked to support a bill to bring about this change. Five arguments favoring the necessary appropriation and justifying the claims of this committee may be summarized as follows: (1) Those wishing to study medicine have not an equal chance with those desiring to take other professional courses but must go outside the state to obtain their professional education. (2) The people of Alabama are deprived of the potential material for medicine because of the added expense incurred in going outside the state for medical education. (3) Alabama is also deprived of the services of many who have thus obtained their medical education elsewhere and never return to their own state. (4) By increasing the number of young doctors in Alabama socialized medicine is dealt a blow in that state. (5) It is not unreasonable to ask that a third of the many millions expended each year for public education be given to medical education for the benefit of that segment of Alabama now discriminated against.

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# From the Secretary's Office

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## County Semi-Annual Meetings

Fairfield County

Tuesday, October 17th

Pickwick Arms, Greenwich

Dr. Milton C. Winternitz, speaker

Hartford County

Tuesday, October 24th

Shuttlemeadow Club, New Britain

Dr. Albert F. Andresen, speaker

Litchfield County

Tuesday, October 3rd

Bantam Lake

Middlesex County

Thursday, October 12th

Edgewood Country Club, Cromwell

New Haven County

Thursday, October 26th

Waterbury, Country Club, Waterbury

New London County

Thursday, October 5th

Uncas-On-Thames, Norwich

Tolland County

Tuesday, October 17th

Windham County

Thursday, October 19th

Putnam Inn, Putnam

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## Doctor Linde Appointed to Tuberculosis Commission

Governor Raymond E. Baldwin has lately announced the appointment of Doctor Joseph I. Linde of New Haven, the President of The Connecticut State Medical Society, to the State Tuberculosis Commission to serve the unexpired term of the late Doctor Stephen J. Maher.

## Study of Prepaid Medical Service

The Committee engaged upon a study of prepaid medical service under the chairmanship of Dr. Samuel C. Harvey is making substantial progress. During the summer a study of medical costs for hospitalization illness was conducted under the direction of Professor John Watkins of the Department of Public Health, Yale University. The results of that study are not yet complete but the information obtained was of great interest. The Committee wishes to thank the members of the Society who cooperated in furnishing data for the study.

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## Mid-Winter Dinner Meeting

Following the vote of the House of Delegates at its Annual Meeting in May, the Society's Program Committee under the chairmanship of Dr. A. Nowell Creadick is arranging the mid-winter dinner meeting of the Society. The program for that meeting has not yet been completed. The meeting will be held late in January or early in February.

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## Directory Cards - Please

There are still about 500 members who have failed to return the 1939 biographical directory cards that were sent out two months ago. Some members have never sent any back since this file was started in 1936. It is to everyone's advantage to have this information accurate and up to date. If you have mislaid the card, another will be sent you on request.

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## SECTION ON Orthopedic Surgery

**Connecticut State Physical Therapy Society.** The Connecticut State Physical Therapy Society was recently organized with Drs. Harry E. Stewart, New Haven, president; Robert E. Peck, New Haven, and Charles Edlin, Waterbury, vice-presidents and Karl B. Bretzfelder, New Haven, secretary. The Society was formally made a section of the Connecticut State Medical Society at its recent annual session.

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**Serial X-ray Examinations.** In Germany special squads of the SS, especially in Frankfurt, have been engaged in taking serial x-ray studies of the entire population. It is reported that approximately 900,000 of such pictures will be taken which will then be studied in the Roentgen Institute of the University of Frankfurt A. M. Mecklenburg has been selected as the district for this first comprehensive x-ray registry of its entire population. The possibilities of such a study from the orthopedic standpoint are fascinating.

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**Death of Arthur T. Legg.** On July 8 Dr. Arthur T. Legg of Boston, assistant professor of orthopedic surgery, died of heart disease, age 65. His outstanding contributions to orthopedic surgery are topped by his original description in 1910 of a disease of the hip known as osteochondritis deformans juvenilis.

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**National Society for Crippled Children.** The section wishes to call attention again to the annual meeting of the National Society for Crippled Children of the United States of America to be held in Dallas, Texas, at the Hotel Adolphus, October 22-26. This is a meeting for lay workers as well as orthopedists and will prove extraordinarily interesting because of the new material that will be presented following the World Congress in London during the month of July.

**Clinical Congress of American College of Surgeons.** Attention is called to a most elaborate program that has been arranged for the presentation of clinical material of an orthopedic character at the annual meeting of the American College of Surgeons in Philadelphia, October 16-20.

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**Tendon Transplantation.** A recent article by Arthur Steindler, "Tendon Transplantation on the Upper Extremity," *American Journal of Surgery*, 1939, 44, 260, carried a statement to the effect that it is essential to preserve the gliding apparatus for the transplanted tendon. He further adds that in the upper extremities, sufficient gliding facilities are provided when the tendons traverse subcutaneous tunnels. This statement by an eminent orthopedist brought to the mind of the author of this section a statement made to the author by Naughton Dunn of Birmingham, England, whom every orthopedist will recall as having contributed a great deal to the science of bone and joint surgery. Naughton Dunn stated that he had had occasion to reopen ten or more cases in which he had transplanted the peroneous longus tendon in the usual manner. In each instance, he removed a section of the surrounding structures for examination. These structures showed that whatever the tissues were through which the tendon had passed, there had been a change in structure with the development of a secreting membrane surrounding the tendon. He believed this highly differentiated connective tissue had given rise to synovial like cells producing a gliding surface. Mr. Dunn added that it was unnecessary to select any particular type of tissue through which the tendon should be passed because any connective tissue would develop these gliding cells and the transplantation would prove successful. He believed the success of tendon transplantation depended upon two conditions, both post-operative in character: (1) early active motion beginning on the fourteenth day post-operatively; (2) wearing a suitable restraining apparatus in the nature of a splint or brace which prevented the tendon, so transplanted, from becoming strained for a period of at least one year.



## SECTION ON Proctology

The fall meeting of the New England Proctologic Society will be held in Bridgeport on Friday, October 13. The program is being arranged by Dr. J. Grady Booe of Bridgeport.

A new book on the Rectum and Colon has just been published by Dr. E. Parker Hayden of Boston, Massachusetts. This volume has a great many practical points and is recommended both for its excellent exposition of the subject of proctology and also for the interesting way in which it is presented. It will be of interest to the members of the Connecticut Society to know that Dr. Hayden is a native of Hartford.

## Our Neighbors

### MASSACHUSETTS

The Committee on Postgraduate Instruction of the Massachusetts Medical Society presented the first annual New England Postgraduate Assembly under the auspices of the society during two days of November 1938. Harvard University provided an assembly hall. Ten out of state physicians were guest speakers. General subjects of medicine were discussed. A registration fee of three dollars was charged, which was sufficient to finance the enterprise. Total attendance was 925, physicians coming from each of the New England states and from seven other states.

The committee on postgraduate instruction of the state medical society, with the cooperation of the Massachusetts Department of Health and the United States Public Health Service, began teaching clinics in gonorrhea and syphilis in December 1938 in Boston and in Springfield. Practical instruction in the diagnosis and treatment of these diseases was continued twice a week for twenty-five consecutive weeks.

### MAINE

In November 1938 the county medical society secretaries voted to endorse a proposal whereby the Committee on Graduate Education of the Maine Medical Association would develop a program of instruction to be given at the various county society meetings of the state. This proposal was presented to the house of delegates of the state association in June 1939 and it is anticipated that it will be put into effect in the autumn of 1939.

At the annual meeting of the Maine Medical Association held at Poland Spring in June the House of Delegates went on record as in favor of a public showing of the movie film, "Birth of a Baby," throughout the state. The House of Delegates voted its disapproval of the Wagner Act and urged opposition of its Congressmen to the passage of the Act.

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### NEW HAMPSHIRE

The New Hampshire Medical Society at its recent annual meeting elected the following officers for the year 1939-1940: —

President: James P. Woodman  
Vice-President: Ezra A. Jones  
Councilors: John J. Brosnahan, Cheshire County; Emery M. Fitch, Sullivan County  
Trustee: Henry O. Smith  
Speaker: Fred Fernald  
Vice-Speaker: Robert O. Blood  
Delegate to A.M.A.: Deering G. Smith; Alternate Delegate: Emery M. Fitch  
Necrologist: Henry H. Amsden

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### NEW JERSEY

Maternity mortality rate for New Jersey for 1938 was 35 per 10,000 live births. This was an increase of 1 per 10,000 over the 1937 rate, due to the rise in the number of deaths from puerperal hemorrhage and other accidents of childbirth in urban counties and to an increase in puerperal sepsis and puerperal hemorrhage in the rural counties.

New Jersey has a higher percentage of colored births than any other Northern State. The death rate among colored patients is higher than among the white, largely due to puerperal sepsis and septic abortions; but the rate has been gradually decreasing to 54 per 10,000 for 1938, the lowest for New Jersey.

The percentage of patients being delivered in hospitals is gradually increasing. In 1938, 78.6 per cent of the deliveries were in hospitals, 17.7 per cent were delivered at home, by physicians, and 3.7 per cent were delivered at home by midwives. In urban counties 81.9 per cent were delivered in hospitals. 14.2 per cent were delivered in homes by physicians, and 3.9 per cent were delivered in homes by midwives. In the rural counties 52.8 per cent were delivered in hospitals, 44.7 per cent were delivered in homes by physicians and 2.4 per cent were delivered in homes by midwives.

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### NEW YORK

An Institute on Diet and Nutrition will be held tentatively on the four Wednesdays during October at the Medical College of Syracuse University. The Institute will be sponsored by the Medical Society of the State of New York through its Council Committee on Public Health and Education of Medicine and the College of Home Economics of Syracuse University, and the New York Dietetic Association. Applications should be sent to Dr. Thomas P. Farmer, Chairman, 206 Sedgewick Drive, Syracuse, New York. The registration fee is ten dollars.

The Associated Hospital Service of New York is revising its contracts after four years of experience. About 57,000 contracts with subscribers who enrolled through individual instead of organized group applications are to be terminated. This change is said to be due to previous insufficient actuarial data.

Dr. Terry M. Townsend, president of the Medical Society of the State of New York, has emphasized the need of practicing physicians keeping abreast of recent advances in medicine. He has stressed the role of county medical societies in keeping its members informed. Realizing this need, the Onondaga County Medical Society has given a series of courses featuring individual instruction. The outpatient facilities of the Syracuse Free Dispensary were utilized. From three to six sessions were held

in each course in medicine, surgery and gynecology. Instructors were chosen from the membership of the county society. Seven courses were offered in the fall of 1938 and from three to five practising physicians enrolled in each. A registration of five dollars was charged to compensate instructors. The program is a permanent activity of the committee on medical education, with the executive secretary of the county society responsible for circularizing the members to determine their needs.

In April 1939 the New York University College of Medicine gave a series of one hour lectures on syphilis five afternoons a week for eight weeks. These lectures were sponsored in part by the United States Public Health Service. No tuition was charged; a federal grant was obtained to finance the instruction.

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### RHODE ISLAND

The Rhode Island Medical Society held a mid winter meeting in January of this year when Dr. Rock Sleyster, President-elect of the American Medical Association, was the guest speaker. He reviewed the steps taken by the American Medical Association to improve the quality of medicine.

The Rhode Island Society lost 18 members by death and 3 by resignation during 1938. With 17 new members added the net loss was 4 leaving total membership of 486.

House Bill No. 782 was passed by the Rhode Island Legislature during its recent session. This bill is an Act to provide a lien in favor of hospitals for services rendered to persons injured as the result of an accident. This lien follows after all legal expenses are deducted. House Bill No. 750 was passed by the Legislature abolishing the office of coroner.

The Cancer Committee of the Rhode Island Medical Society proposed at its meeting to consult with the presidents of four colleges in the state as to the advisability of starting a course on cancer in their various institutions. This would be an optional course and would be given preferably to students taking premedical courses.

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## - NEWS -

### *from County Associations*

#### Fairfield

Believing that in the past golf and other social activities had offered strong competition to the scientific part of the fall meeting of the county association, The Stamford Medical Society put on an entirely recreational program. To this gathering on the fourteenth of September came more than a hundred members of the Fairfield association. Golf and tennis were followed by a good dinner. It was the opinion of those present that the precedent thus established should become an annual event.

After this pleasant get-together the decks should be cleared for a purely business and scientific meeting on the seventeenth of October. This, the semi-annual meeting will be held at the Pickwick Arms in Greenwich at eight thirty in the evening. The first paper of a series on the general subject of "Infection" will be presented by Dr. Milton C. Winternitz, professor of pathology at Yale. Subsequent meetings to present other aspects of this subject will be held with each local society in the county.

#### Hartford

With vacations over, we now look forward to the resumption of meetings — City, State, County, Hospital and National. Considerable interest has been in evidence in regard to the Clinical Congress, the Hartford County Medical Association meeting and the meeting of the American College of Surgeons. Many have expressed their intention of attending some of these valuable affairs. The semi-annual meeting of the Hartford County Medical Association will be held on October 24, 1939, at the Shuttle Meadow Country Club in New Britain. Facilities for golf and other sports are available in the afternoon and a dinner will be held in the evening.

The Dillon Memorial Building, the new and unique building of the St. Francis Hospital, Hartford, which was donated by Miss Catherine Dillon of Hartford in memory of her brothers, Edward and Charles, was auspiciously dedicated on September 8, 1939, by Bishop Maurice F. Mc-

Auliffe. Delegations from various organizations and societies, besides many friends and workers of the hospital were present. Fulfilling a need of some years, the building is unique inasmuch as it constitutes in itself a complete hospital unit for the care of all diseases and conditions of children exclusively. Among many modern features, several might be mentioned such as: 1. Noise-proof; 2. Accoustic ceilings; 3. Air-pad rubber flooring; 4. Enunciator system; 5. Radio pillows; 6. Indirect lighting in private rooms; 7. Inclosed pent-house; 8. Open sun-roof; 9. Automatic elevators; 10. Air-conditioned nursery; 11. A new pathological laboratory. Mother M. Xavier, Superintendent of St. Francis Hospital, among other remarks stated, "This gift is an expression of rare munificence for which the public of Hartford should be grateful. Far into the years, the unselfishness of Miss Dillon will be the means of bestowing better health on the youth of Hartford."

Doctor Mario L. Garafolo assumed his new duties as the head of the Department of anesthesia of the St. Francis Hospital, Hartford, on September 15, 1939.

It is good to learn that Dr. H. N. Costello, President of the County Medical Association, and Dr. James E. Davis are well on the road to recovery following their recent illnesses.

Dr. William J. Neidlinger was married on September 9, 1939, to Nancy Pickering in Watch Hill, Rhode Island.

The Board of Directors of the Hartford County Medical Association, at its meeting September 13th, 1939, voted to go on record as approving the new draft of the by-laws. Copies of this new draft will be mailed to each member of the Association in order that new members may study it and come prepared to take action on the matter at the next regular meeting, Tuesday, October 24th, 1939.

Dr. Harry L. F. Locke, Chairman of the Medical Information Bureau, has announced the date of the 2nd annual special meeting under the joint auspices of the Hartford Medical Society and the Hartford County Medical Association. This will be held at the Bushnell Memorial in Hartford, October 16, 1939, at 8 P.M. The speaker will be the noted neurologist of New York, Dr. Foster Kennedy, and his subject will be "Emotional Unrest in a Restless World."

Drs. Maurice Root, Thomas Denne and George Lundberg comprise a sub-committee making arrangements for this meeting.

The Committee on Arrangements for the State Medical Society Meeting to be held May 21st 22nd and 23rd, 1940, in Hartford, is composed of the following:

T. W. Worthen, Chairman	Hartford
B. B. Robbins	Bristol
W. T. Morrissey	New Britain
D. C. Y. Moore	Manchester
E. J. Turbert	Hartford
C. B. Brainard	Hartford
P. J. Steincrohn	Hartford
F. T. Oberg, ex-officio	Hartford

Dr. Samuel D. Lewis of East Hartford is spending a year in the study of Ophthalmology in New York City.

Dr. Walter Weisenborn, Secretary of the Hartford Hospital Golf Association, reports that a very successful and pleasant outing of that organization was held at the Farmington Country Club on September 14, 1939. One hundred and two members of the hospital staff and hospital alumni attended. During the afternoon various sports were indulged in and the competition in all events was between the medical and surgical representatives — golf, baseball, bowling on the green (and off), horse-shoe pitching, bridge, etc. The medical men were victorious, thus breaking a tie which had held for several years, the defeat administered to the surgeons in baseball being quite decisive, namely, 57 to 7. A handsome silver cup was received by Dr. John Wentworth on behalf of the medical men. This was presented by Dr. William L. Gills, the retiring president of the association. Dr. William Goodrich of Waterbury won the sweepstakes in golf, Dr. Charles Mirabile had low net and Dr. Elliot Cogswell won the kickers handicap. Officers elected for the coming year are:

Dr. Freeman Clason, President  
 Dr. Frank Wood, Secy.  
 Dr. Lawrence Cogswell, Treas.

A banquet was held in the evening.

Correction: In the last issue of the Journal under the notes from Hartford County, a typographical error occurred concerning Dr. Charles Mirabile. He was certified by the American Board of Urology following examinations held at White Sulphur Springs, West Virginia, instead of by the Board of Neurology as reported.

## Middlesex

On September 8, 1939 ceremonies were held at the Connecticut State Hospital in Middletown in connection with re-laying of the original cornerstone and placing of a new stone at the central building. Lieutenant Governor James L. McConaughy laid the stones in the absence of Governor Baldwin and read an address prepared by the Governor. The records contained in a lead box which were removed from the original cornerstone laid in 1867 were replaced along with present day documents of a similar nature. The building program will relieve badly overcrowded wards and provide better facilities for tuberculous patients. The laboratory has been completely rebuilt and enlarged. Dr. Roy L. Leak, Superintendent of the Hospital, responded with a brief address in which he thanked the Governor and the General Assembly for the improvements. The Chairman of the Board of Trustees, Professor George M. Dutcher of Wesleyan, was chairman of the program. Reverend Doctor Frank M. German and Reverend Robert J. Bowen, both of Middletown, offered Invocation and Benediction, respectively.

The Middlesex Hospital in Middletown was the grateful recipient recently of a Castle operating room light which has been installed in one of the delivery rooms. The donor was Mrs. William W. Wilcox, Jr., of Middletown. The hospital has also installed two new incubators, one in the nursery and one in the children's ward. A follow-up service asking for critique of hospital care has been instituted. Each patient discharged from the hospital receives, a short time later, a letter requesting suggestions for the improvement of hospital care. To date several excellent suggestions have been received which are receiving consideration.

The Hospital is making every effort to co-operate with its staff physicians. Each ward patient now receives a financial investigation and when the financial status is deemed satisfactory, hospital care in semi-private or private accommodations is urged. From July 1, 1938 to August 31, 1939 the hospital has admitted 127 patients under the Plan for Hospital Care, Inc. These admissions represented 772 hospital days and the hospital was compensated \$5,436.00 for this care through the Hospital Plan.

Dr. Louis O. LaBella and Dr. Joseph Magnano, Officers of the Medical Detachment of the



169th Infantry, took part in the army maneuvers at Plattsburg, New York, last month.

Dr. Jessie W. Fisher and Dr. Ella Wilder have returned from trans-continental vacation trips

Dr. George Armstrong, a member of the staff of the Connecticut State Hospital, has returned from the New England Baptist Hospital in Boston where he was a patient for several weeks. He is convalescing satisfactorily.

Dr. Harry S. Frank, President of the Central Society, recently underwent a major operation in the New England Baptist Hospital in Boston. He is now convalescing at his home in Middletown.

### DIRECTORY OF PHYSICIANS OF NEW YORK, NEW JERSEY AND CONNECTICUT

#### Publication Offering

The Directory of the Physicians of the States of New York, New Jersey and Connecticut which is published by the medical societies of those states will be available about January 1, 1940. Members of The Connecticut State Medical Society and all hospital and public health executives in the State of Connecticut may make pre-publication subscription to this Directory at \$3.00 per copy. After publication the price will be \$6.00. The information contained in this Directory has been accurately compiled by the Secretary's Office and includes a listing of all physicians in the State, with address, telephone number, school and date of graduation, specialists rating and hospital connection; all hospitals with a complete list of professional staff of each hospital, and the organization and personnel of all public health departments. It is the complete medical directory of this locality.

Prepublication subscriptions should be mailed to The Connecticut State Medical Society, 258 Church Street, New Haven, without delay, including the remittance of \$3 00 for each copy ordered.

### ANNUAL REPORT OF ROCKEFELLER FOUNDATION

The 1938 Annual Report of the Rockefeller Foundation is now off the press. It contains factual data of considerable interest together with twenty seven illustrations culled from all over the world and representing various phases of its work. Of over \$15,000,000 appropriated by the Foundation during 1938, \$3,800,000 were given to medical sciences and \$2,500,000 to public health. As its income for the year was only about \$7,000,000 it was necessary to secure the balance from surplus carried over from previous years and from the principal fund. The Foundation appropriated over one and one-half million dollars to the China Medical Board for support of the Peiping Union Medical College over a four year period. The American University of Beirut received one million dollars toward the endowment of its medical school. The Institute of Public Relations at Yale received \$700,000.

An extensive program of vaccination against jungle yellow fever was carried out in South America. The problem of the anopheles gambiae in Brazil has enlisted the efforts of the Foundation. The major activity of the Foundation in the medical sciences since 1932 has been in psychiatry, neurology, and related subjects. During 1938 the general field of mental hygiene also received large appropriations. Four Medical schools in this country and one in Syria received grants for the general development of certain departments. The Foundation recognizes opportunities ahead in the fields of chemotherapy, dermatology, pharmacology, legal or forensic medicine, industrial medicine, dentistry, public health and the diseases of advancing years. Of particular note among the new developments in medicine in which the Foundation is interested are the Research Council of the Department of Hospitals of New York City, the National Committee on Maternal Health, the Commission on Graduate Medical Education, the Dartmouth Eye Institute at Dartmouth College and the investigations at the Massachusetts General Hospital under Doctor Fuller Albright.

The report covers 515 pages, is bound in paper and may be obtained from the Rockefeller Foundation, 49 West 49th Street, New York.

## SPECIAL NOTICES

### ANNUAL MEETING OF ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

The forty-fourth annual meeting of the American Academy of Ophthalmology and Otolaryngology will be held in Chicago October 8-13 at the Palmer House. The Academy will again present its elaborate courses of instruction with more than 100 specialists as teachers; four afternoon programs of motion pictures and a scientific exhibit in addition to its formal scientific program.

There will be one joint session at which Dr. George M. Coates, Philadelphia, will deliver his presidential address and Dr. Burt R. Shurly, Detroit, will be introduced as the Academy's guest of honor for the year and will deliver an address.

At this session a symposium on essential hypertension will be presented by Drs. Albert C. Furstenberg, Ann Arbor, Mich., speaking from the standpoint of the otolaryngologist; Henry P. Wagener, Rochester, Minn., the ophthalmologist and Roy W. Scott, Cleveland, the internist.

Two foreign guests will address the section meetings, which will be held on alternate afternoons. These guests are Prof. Joseph Igersheimer, Istanbul, Turkey, who will discuss "The Optic Nerve and Diseases of Hypertension," and Arthur DeSa, Pernambuco, Brazil, who is to speak on "Ethmoiditis."

Among the speakers announced for the sections are:

Drs. Bennett Y. Alvis and Meyer Wiener, St. Louis, A New Technic for Corneal Transplantation by Means of a Uniform Graft Mechanically Obtained.

Dr. O. Jason Dixon, Kansas City, Mo., A New Plastic Operation for the Relief of Conductive Deafness.

Dr. Arthur W. Proetz, St. Louis, Effects of Tobacco (Smoking) on the Respiratory Tract.

Dr. John B. Hitz, Milwaukee, Visual Testing Methods in Schools.

Dr. William M. Muncy, Providence, R. I., Relationship of Vitamin Deficiency to Trypsinamide Reaction.

Dr. Thomas E. Carmody, Denver, The Epipharynx — The Almost Unknown in Otolaryngology.

Dr. Edwin H. Campbell, Philadelphia, Results in the Labyrinth Fistulization Operation for Chronic Progressive Deafness.

Dr. Frank J. Novak, Jr., Chicago, Innocuous Oils Useful in Rhinologic Practice in Contrast to the Use of Hydrocarbon Oils.

Dr. William Thornwall Davis, Washington, D.C., Treatment of Accommodative Convergent Squint.

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### NEW ENGLAND POSTGRADUATE ASSEMBLY, SECOND ANNUAL SESSION

The New England Postgraduate Assembly will hold its second annual session at Sanders Theatre, Cambridge, Massachusetts on October 31 and November 1. The list of speakers includes leading medical authorities from seven states, the District of Columbia, Canada and England. The registration fee is three dollars and applications should be mailed to the Postgraduate Assembly, 8 Fenway, Boston. Every doctor in New England is cordially invited to attend.

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### TWENTY FOURTH INTERNATIONAL MEDICAL ASSEMBLY

The International Medical Assembly Interstate Medical Association of North America will hold its twenty-fourth session in Chicago on October 30, 31, November 1, 2, and 3. An unusually interesting clinical and didactic program including all branches of medicine and surgery and the specialties has been arranged by the program committee.



## • OBITUARIES •

### CALVIN HAYES ELLIOTT, M.D.

1879-1938

Dr. Calvin Hayes Elliott was born in Hartleton, Pennsylvania, January 12, 1879. From public school, he attended Bucknell Academy and Bucknell College, from which institution he graduated in 1900 with the degree of Bachelor of Arts, receiving his Master's degree the following year. While at Bucknell he was one of the outstanding athletes and his scholastic achievements were such as to gain for him a scholarship which admitted him to medical school — Medico Chirurgical — graduating therefrom in 1905 with the degree of Doctor of Medicine.

For his internship, he went to Harrisburg, Pennsylvania, to the Pennsylvania State Hospital for the Insane. It was while serving there that he all but died from a ruptured appendix, when only his indomitable courage, a trait conspicuous throughout his life, pulled him through. From his sick bed he married Miss Nellie Dunkle, of Lewisburg, and following convalescence returned to Harrisburg to finish out his internship.

The ensuing four years were spent in the western part of Pennsylvania at Merrittstown, where, in addition to carrying on a general practice, he served as Surgeon for the Monongahela Railroad at Brownsville. It was here in 1911 that their first child, a girl, saw the light of day.

In 1912 Dr. Elliott gave up his practice and spent a year in study abroad, the better part of the time in Germany and Austria, finishing in Edinburgh, preparatory to his chosen specialty.

On returning to America and after considering various contacts, it was largely through the influence of Dr. O. C. Smith that he decided on coming to Hartford and he was licensed to practice here in 1913. On December 1, 1915, he was appointed to the staff of the Hartford Hospital as Assistant Gynecologist and Obstetrician, a position which he filled creditably and faithfully, being elevated to Visiting Staff on October 3, 1934.

In addition to his Hartford Hospital affiliations he was consulting Gynecologist and Obstetrician to many of the hospitals of the surrounding

towns and also served as consultant to the Neuro-Psychiatric Institute and as Visiting Gynecologist to the Hartford Municipal Hospital.

Dr. Elliott was an active member in the Hartford Medical Society, Hartford County Association, Connecticut State Society, American Medical Association, New England Obstetrical and Gynecological Society, Connecticut Obstetrical and Gynecological Society and Fellow of the American College of Surgeons.

In addition to his scientific affiliations, he was an ardent Rotarian, a 32nd degree Mason, and enjoyed membership in many local clubs.

In 1917 Dr. and Mrs. Elliott were blessed with a second child, a boy, and this completed their family.

March 15, 1938 at Tucson, Arizona, Calvin Hayes Elliott passed away. He had been ailing for a long time, and absent from his practice since April, 1936. Multiple abscessed teeth were a large contributing factor in the onset of his breakdown, allergies, secondary anemia and nephritis developing. Repeated transfusions, changes of climate, all measures attempted only served to delay his demise. In November, 1937, two weeks were spent in the Cleveland Clinic where a thorough investigation was made but to no avail.

In accordance with his wishes, a post mortem examination was done and the remains cremated, the ashes being brought back to his old homestead in Lewisburg, Pa. and, as he requested, "laid to rest without any ado." There was no evidence of malignancy.

No brief resume of the material facts of his life can give a true picture of the worth of Calvin Elliott. As has been said, "He was a physician in a much broader sense than the term usually implies, in that his great human sympathy, his broad understanding and his philosophies of life were generously and intelligently and unsparingly given in his constant endeavor to serve humanity."

Notwithstanding the eminence attained in his chosen specialty, he manifested those qualities of the real general practitioner, dispensing that undefinable therapy of sympathetic understanding, hope and courage. He understood human nature thoroughly.

He loved the great out-of-doors, nature in all phases of its majestic grandeur and beauty. Automobiles were one of his hobbies, as we know,

and he drove countless miles and was familiar with most of the beauty spots of New England and adjoining states. Driving was his chief recreation and he never seemed to tire of it.

He was always helpful to the younger members of the profession and an inspiration to them in starting out in their chosen careers. And how he did love to talk and always had something to contribute, whether it be scientific or of plain human interest, and those of us who knew him best will always cherish the memory of that friendly, helpful trait.

His bigness of nature, his genial manner, his wonderful smile, his indomitable courage and his untiring devotion to his patients, rich and poor alike, will be cherished memories always.

"To live in hearts we leave behind is not to die."

Glover E. Howe, M.D.

## • Quarto Notes •

### HEADACHE AND HEAD PAINS

A Ready Reference Manual for Physicians  
by

Walton Forest Dutton, M. D.

300 pp.

\$4.50

Philadelphia

F. A. Davis Co.

1939

"Headaches and head pains are essentially symptoms of many disease processes or functional disturbances. Probably no sources of pain compare in frequency to these symptoms in the large majority of patients who seek medical aid. The problems of differential diagnosis, of pathological processes, or of surgical technic may engage the primary interest of the scientific physician and surgeon, but the suffering patient requires the alleviation of pain as a crying need."

So does Dr. Dutton begin the preface to his book, and in support of this thesis he lists alphabetically and describes briefly over two hundred organic and functional disturbances having cephalalgia as a prominent symptom. Of necessity the descriptions and diagnostic criteria are greatly abbreviated in a compendium of this type. But there is no dearth of suggested remedies in full prescription form, with detailed directions as to their use and frequency of administration. Most of these are directed to the alleviation of the headache or head pains, but some are for the specific treatment of the underlying pathology. At the end of the book are some thirty-seven pages of summary of drugs and procedures advocated for the more

common causes of cephalalgia, followed by an alphabetical index of remedies.

This reviewer objects very strenuously to the fact that the name of one Pharmaceutical House is specified on some forty U.S.P. drugs in this index. Such a procedure seems hardly in keeping with a scientific book in medical practice.

Of all the conditions noted, it seems to the reviewer that an undue amount of space is devoted to the types, diagnosis and treatment of constipation. Also fourteen pages on the use and technic of self-administration of enemata seem hardly pertinent to the subject.

The sections on headache itself and trigeminal neuralgia are among the better ones of the whole volume.

The book itself is well printed in large clear type and as a reference manual, it should be of considerable practical value to the busy physician in furnishing clues to the conditions underlying cephalalgia as a prominent symptom.

R. L. Gilman

### PROCTOLOGY FOR THE GENERAL PRACTITIONER

by

Fred C. Smith, M.D.

386 pages

\$4.50

Philadelphia, Pa.

F. A. Davis Co.

1939

This is as its name indicates, truly a book for the physician doing general practice. It is simply written, and while some of its descriptions are verbose, it is quite easy reading. Some of the descriptions of treatments and surgical procedures might well have been abbreviated, for lack of good illustrations makes a thorough understanding of the technique very difficult, as is true of any technical word description. Actual observation and experience are required to understand and learn surgical procedures.

It is a pity that a book published on a basis of experience should have so few original illustrations. Actually 38% are not credited to other texts.

There are several points in the book that are worthy of commendation. First, the frequent warning about failure to diagnose cancer of the anus, rectum, and colon. After all, the general practitioner has the first opportunity of seeing the patient and all too frequently a self diagnosed case of bleeding piles is treated with an ointment or suppositories, without examination.

Again, something new to appear in print in this country, is the antagonism to surgery in the treatment of strangulated hemorrhoids. Dr. Smith's treatment is used widely, but no one has ever come out in print denouncing surgery for this acute condition.

Another point worthy of mention is the author's correlation of ano-rectal with genito-urinary symptoms.

Throughout the text, the occasional case history is interesting and quite forceful in emphasizing points of discussion.

A. Taylor



## A CONVENIENT OFFICE TREATMENT FOR TRICHOMONAS VAGINITIS

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Complete remission of symptoms and removal of the trichomonad from the vaginal smear usually is effected following the Silver Picrate treatment for trichomonas vaginitis.

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### THE ART OF ANESTHESIA

by

Paluel J. Flagg, M.D.

491 pages 161 illustrations 6th edition revised  
J. B. Lippincott Co., Philadelphia, Pa. 1939

It has been said once a book survives five editions the author has no need to apologize for his work because to do so would reflect on the judgment of those who had acquired it. In general it may be said that readers sometimes wonder if such an idea has not been responsible for the willingness with which an author offers a sixth edition that includes a revision of the old text, with some new material added, when a thorough overhaul of old material in the light of newer concepts is indicated. Viewing in retrospect an experience of twenty-five years, the author has aimed to provide a groundwork upon which the student, interne, and general practitioner may acquire a comprehensive knowledge of the "Art of Anesthesia." In this effort, attention is directed primarily to inhalation anesthesia and methods of resuscitation. The factors and phases in many instances are described and explained on the basis of the author's own point of view, rather than in conformity with the opinion of other well recognized authorities in the specialty. It is for this reason that the book is interesting to an older anesthetist, and a younger anesthetist may be led to realize that maintenance of an open mind regarding many things, that he has been taught, is necessary.

R. M. Tovell

### TUBERCULOSIS DEATHS AMONG YOUNG WOMEN

The excess of deaths from tuberculosis among young women over that of males of the same age has long been regarded as an enigma by the medical profession. In an exhaustive study made in New York and Detroit, every death during one year from tuberculosis among young women was carefully investigated and several facts emerged from an analysis of the material obtained.

School life, race, nativity, participation in industrial life, insufficient clothing, poor food habits including the ever-present dieting fads, lack of sleep and too much recreation seem negligible in their influence. The real hazard is the psychic and physical changes attendant upon adolescence and maturity. Early marriage and child-bearing increase the death rate from tuberculosis in this group. Nicholson, E., Study of Tuber. Among Young Women, N.T.A. Social Research Series No. 7.

## SCOLIOSIS: A RATIONAL FORM OF TREATMENT

(Concluded from Page 551)

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Hamsa, W. R. Evaluation of Scoliosis Treatment. Nebraska State Med. Journ. 23, 4, 137, April 1938.



## CESARIAN SECTION

Hospitals should not permit the performance of cesarian sections without a routine requirement of consultation with a competent obstetrician. The type of section to be chosen should be decided at this consultation, because one type of operation may be safer than others under certain circumstances. Both the incidence and the danger of cesarian section could be diminished if general practitioners attending obstetric patients would arrange for their primiparous patients to have at least one consultation with a competent obstetrician late in pregnancy.

*Titus—N. Y. State Jour. Med., June 15, '39*

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12 years old.  
Both 86.8 proof.

Canada Dry Ginger Ale, Inc., New York, N. Y.; Sole Distributors

*Your Patronage Is The Answer*



## STATE DEPARTMENT OF HEALTH MATERNAL CARE PROGRAM

(Concluded from Page 569)

up to the seventh month and every two weeks during the remaining period of pregnancy.

3. She should eat an adequate and well balanced diet which will provide for the needs of her own body as well as for her growing baby.
4. Every woman should have a dental examination early in pregnancy and should have careful dental supervision during the prenatal as well as during the postnatal periods.
5. Every prospective mother should have the benefit of skilled medical and nursing care at the time of delivery, and she should have the opportunity for good hospital care if needed.
6. Every woman should have good medical and nursing care and instructions throughout the lying-in period.
7. Every woman should have an examination six weeks after the birth of her baby to be sure she is in good condition.

Through direct and indirect educational methods the State Department of Health carries on a program for maternal care which includes inspection and licensure of maternity hospitals, supervision of midwives, instruction as to the need of medical care and distribution of health literature to the public.



## CURETTAGE IN SEPTIC ABORTION

William E. Studdiford, M.D., of New York City, in the New York State Journal of Medicine for July 1, 1939, advocates curettage in patients with incomplete abortion and fever, provided the uterus is freely movable, there is no parametrial thickening and tenderness, and the cervical cultures do not show a predominance of hemolytic streptococci. By this procedure hospitalization has been reduced to an average of 6.9 days, the average postoperative stay being 2.9, excluding the day of operation. The author reports a mortality of 1.1 percent under this regime.

## SAYS JUSTICE DEPARTMENT WOULD DOMINATE AMERICAN MEDICINE

"The conclusion seems inescapable that the Department of Justice has embarked on a course of prosecution if not persecution of the medical profession in this country with a view to forcing its contention as to what should be the nature of medical practice in the United States," says *The Journal of the American Medical Association* for Aug. 5 in commenting on the press release of the Department of Justice, issued after the United States District Court in Washington, D C, on July 26 had quashed the indictment of the Association for violation of the Sherman Anti-Trust Act.

After pointing out that in the same issue is published the complete text of the opinion of Justice James M. Proctor, together with transcripts of a number of newspaper editorials on the decision and a press release issued by the Department of Justice indicating that further action is contemplated by the Department in relation to this case, *The Journal* editorial says:

"After indicating the nature of the indictment and the five forms of conspiracy that were charged, Justice Proctor listed the chief contentions of the demurrer. It is his opinion that medical practice is not a trade within the meaning of section 3 of the Sherman act. Particularly interesting in Justice Proctor's opinion is his analysis of the indictment. Thus he said:

The defendants have raised objections to the sufficiency of the indictment as a pleading. These go mainly to the claim that many of the allegations dealing with essential and material features of the charge are vague, indefinite and uncertain. The objections are far too numerous to deal with separately. There is merit to many of them. The indictment is afflicted with vague and uncertain statements. In some instances material facts are altogether lacking.

"Moreover, he said in relation to that part of the indictment which contained the charges against those indicted:

The inducement, as well as the charging part, setting forth the plan and purpose and acts done to effectuate the conspiracy, abound in uncertain statements. Inference, opinion and conjecture are also freely indulged. This is especially so in the inducement, much of which seems unnecessary to a statement of the charge. It is question-

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able whether some of it would be deemed relevant and competent in proof of the offense. Every indictment should be confined to a clear and dispassionate statement of essential fact. Thus an accused can better know the exact offense with which he is charged and will not be confused in making his defense. Ordinarily improper matter in the indictment unnecessary to support the charges will not vitiate the indictment. It will be treated as surplusage and disregarded. But I doubt if such treatment would suffice to relieve these defendants of the prejudice likely to arise by an indictment which smacks so much of a highly colored, argumentative discourse against them. It must be remembered that when a case is finally submitted to a jury for their secret deliberations the indictment goes with them.

"In its press release, the Department of Justice indicates that it will seek a reversal of the decision handed down by Mr. Justice Proctor. It makes the statement that the release is issued not for the purpose of commenting on the opinion but for the reason that it is important to inform physicians generally that, until the Supreme

Court has acted, the government policy toward boycotts in the medical profession is unchanged. The Department of Justice says further that it will use every effort to get a final decision from the Supreme Court at the earliest possible moment and that it may consider the possibility of calling another grand jury to consider another indictment in a different technical form. Finally the Department of Justice states that announcement of the exact steps which will be taken by the government will be made within the next ten days.

"In response to this pronouncement of the Department of Justice, Mr. Seth W. Richardson, one of the attorneys representing the American Medical Association, gave the following interview:

The warning issued by the Anti-Trust Division (of the Justice Department) to the medical profession generally, following the filing of the decision of the District Court on demurrer, was both impertinent and unnecessary.

It was impertinent because, as the division should know, the government has no jurisdiction whatever over the medical profession, save in the

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District of Columbia, and medical men elsewhere need pay no attention to the threats of the Anti-Trust Division.

*The 'warning' was unnecessary because the members of the medical profession did not, do not and will not violate any of the anti-trust or other statutes in the pursuit of their calling.*

Finally, with reference to the statement of the division that the present decision is not a controlling precedent and that new grand jury proceedings may follow, it is sufficient to reply that until the present ruling is reversed counsel for the defendants believe that it stands as an effective bar to any similar abortive attempts on the part of the division to make further legal 'experiments' upon the doctors in the District of Columbia.

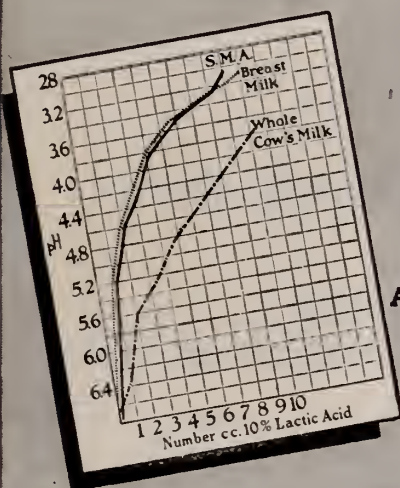
"The conclusion seems inescapable that the Department of Justice has embarked on a course of prosecution if not persecution of the medical profession in this country with a view to forcing its contention as to what should be the nature of medical practice in the United States. Failing to obtain a consent decree, it proceeded to secure an indictment. Attorneys for the American

Medical Association obeying the mandate from its Board of Trustees, sought to obtain a quashing of the indictment by filing of a demurrer. Now Justice Proctor has declared in no uncertain terms that the demurrer is sustained and has indicated that much of the language of the indictment is 'highly colored, argumentative discourse.' Not satisfied with this decision, the Department of Justice proposes to continue to seek to undermine the confidence of the people in the medical profession. The question may well be asked as to whether or not this is justice or persecution. The members of the House of Delegates of the American Medical Association have authorized the Board of Trustees and the officers to utilize to the utmost the resources of the Association in combating this attack by the Department of Justice. The opinion of Justice Proctor lends encouragement and is an inspiration to continuous effort in behalf of a free profession. The medical profession of this country will not be coerced, threatened, abused or otherwise maltreated, and it will fight to the finish when its high traditions demand a righteous resistance."

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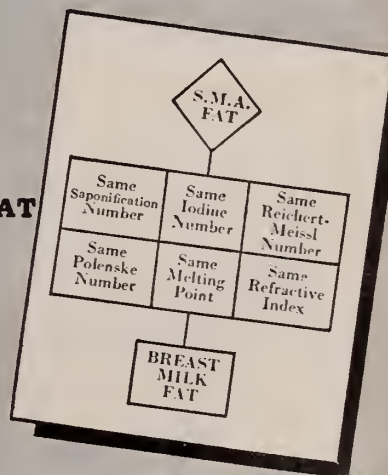
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\*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

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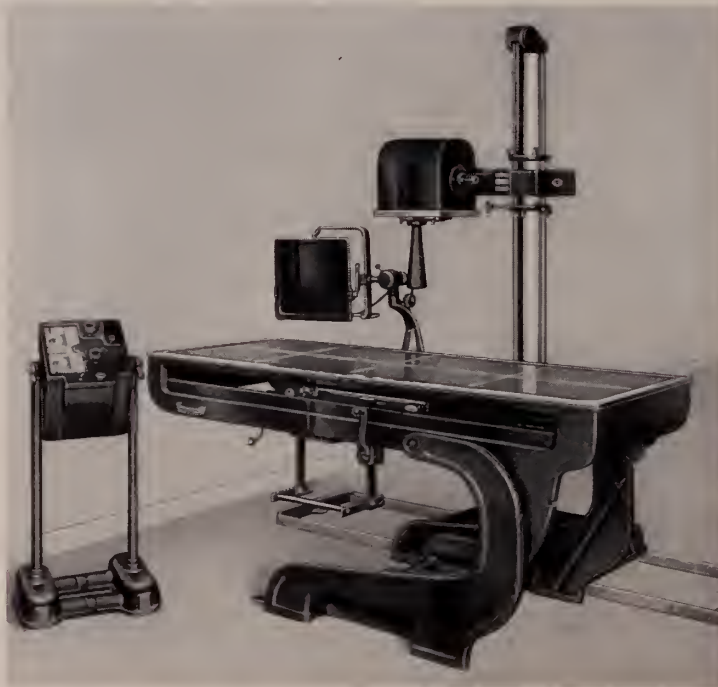
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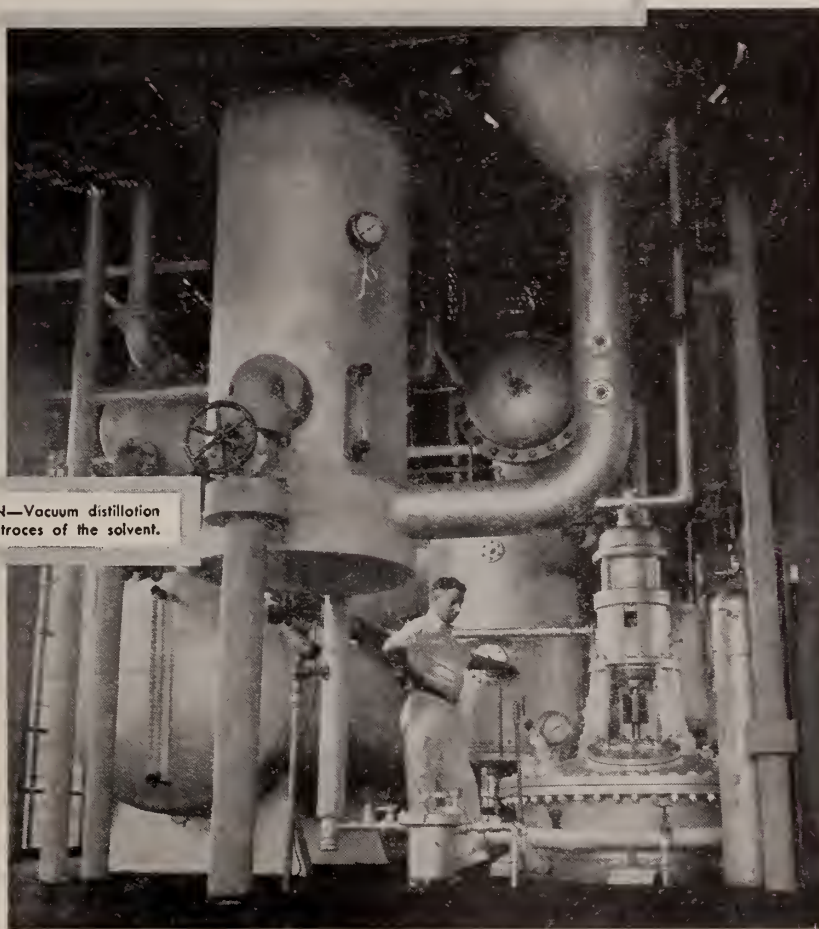


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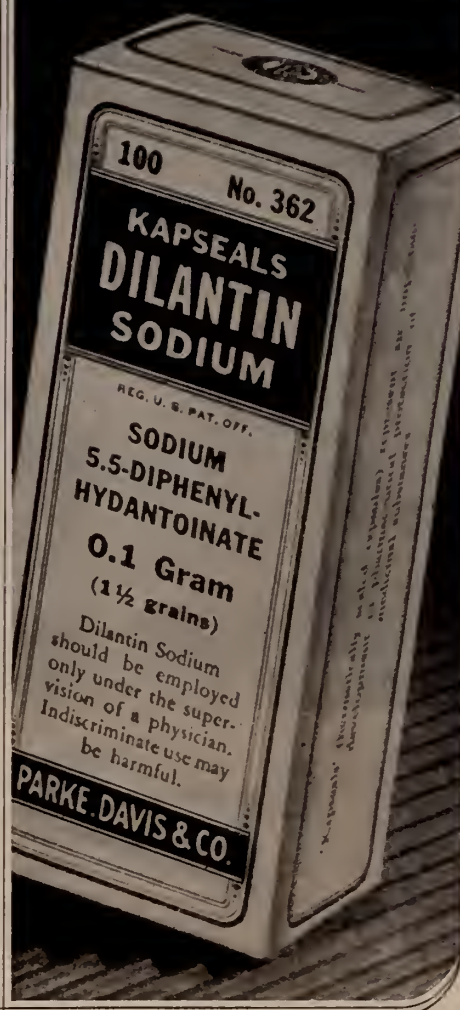


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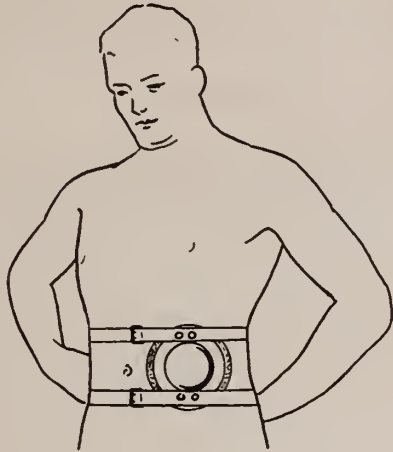
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Daily blood counts and urinalysis should be made for evidence of hemolytic anemia, leukopenia and hematuria. One of the most serious complications that should be looked for is interference with kidney function.

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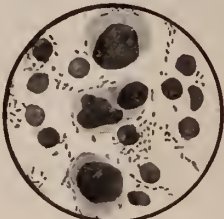
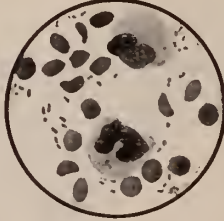
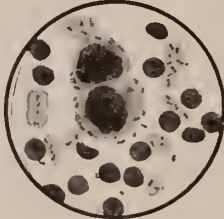
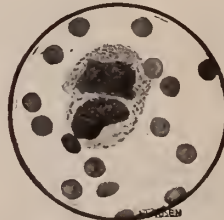
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(Based on bone marrow culture studies of Bullowa and Osgood—*Jour. Mich. State Med. Soc.*, July, 1939, Vol. 38, No. 7, p. 563)

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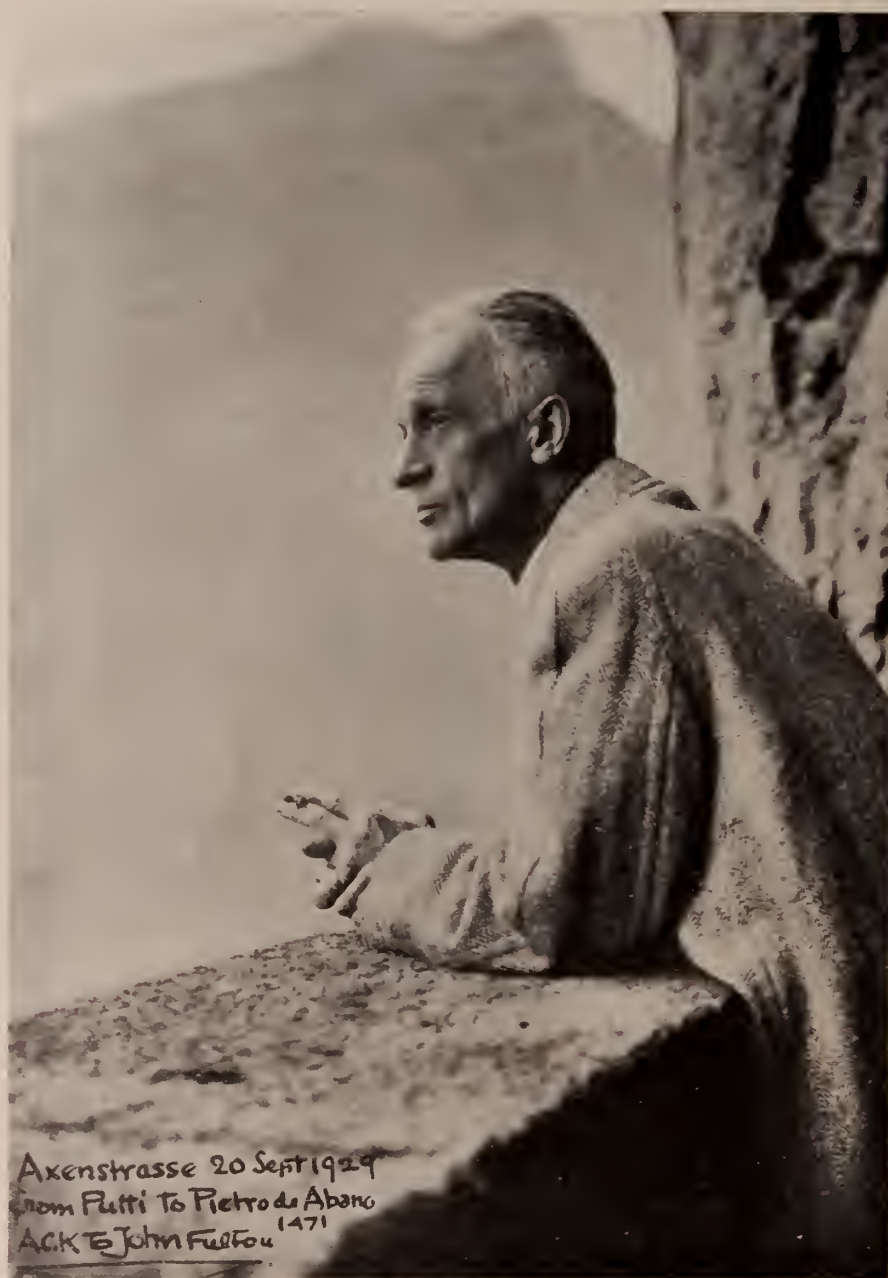
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## HARVEY CUSHING

April 8, 1869 — October 7, 1939

In Connecticut this autumn there is just cause for sadness, for with the fading of the richly colored foliage there ended the glorious career of an adopted son, whose memory will be cherished always.

Harvey Cushing was born in Cleveland, Ohio, of a distinguished line of physicians. Yale gave him his bachelor's degree and a lasting interest in his college and its beautiful countryside. This made it easy for him, years later after his retirement in Boston, to move to New Haven, which he regarded as his second home.

The interval of forty odd years between his two sojourns at Yale was scarcely sufficient for the accomplishments of this wiry, vigorous man. He prepared himself with a medical schooling at Harvard and a house service at the Massachusetts General Hospital, and then gained surgical skill under Halsted at the Johns Hopkins Hospital, where, too, he found enduring inspiration and guidance from Osler. After studies abroad with Kocher, Kronecker and Sherrington, he returned to Baltimore where he developed and later at Harvard perfected a daring and meticulous technique for the surgery of the brain.

The school of neurosurgery which he thus developed was based not only on manual dexterity, which was no less the pride of his baseball and tennis days as it was the marvel of his last great meningioma operation, but was aided by teamwork, and founded upon a knowledge of every detail of the patient's malady and its treatment. The minutiae which were so important for the successful outcome of his difficult cases were painstakingly worked out in the laboratory or clinic with the aid of his pupils. Thus came our knowledge of the dynamics of intracranial pressure and the circulation of the cerebrospinal fluid, methods for hemostasis including the use of silver clips, and the natural history and classification of tumors of the brain. Because of many contributions to the physiology of the pituitary body he rightly became the father of its study. His constant quest for improvements in technique led to his early adoption of methods for the recording of blood pressure during operations, and in collaboration with Professor Bovie to the perfection of the high frequency electrical current for the control of hemorrhage in surgery of the brain.

While carrying the constant burden of a busy neurosurgical clinic, the teaching of medical students, and the administration of a department, he made in literature also a career which reached its highest point in the *Life of Sir William Osler*. Although laboriously attained, his mastery of the technique of writing became such that the smallest paper or address revealed grace and precision in the expression of his meaning. Through the years he found relaxation in assembling what came



ultimately to be a superb collection of books of significance in the history of medicine, now his tangible legacy to Yale.

During the Great War he served in the British and American forces in France. While working with an American Base Hospital Unit behind the British lines, he adapted his own careful surgical technique to the principle of early *debridement*, then advocated by certain French surgeons, and thus evolved a method for the treatment of cranio-cerebral injuries which greatly reduced mortality. Later he became the senior consultant in neurological surgery in the A. E. F. None of this interrupted his habit of keeping a personal journal, and portions of the account of these war-time days were later published.

Dr. Cushing even in the busiest times aided his pupils or house officers with their writings, and listened sympathetically while they expressed their views concerning current experiments. It seems incredible that he willingly took so much time from his crowded hours to struggle painstakingly over their writings or medical illustrations. In these latter, he, too, was an expert having studied anatomical art with Brodel at Hopkins. Working with him his men were thus led to their greatest efforts and highest aims. They knew that no matter how hard pressed they were, the "Chief" himself set a sterner pace. Sometimes when the strain seemed almost too great, he would, at the crucial moment, make a warm and fatherly gesture that instantly renewed one's vigor. How generous and thoughtful were these quiet deeds of his may never be known, save perhaps some day by a glimpse at the letters he received from former pupils.

The last active years at the Peter Bent Brigham Hospital passed rapidly with his greatest interests centering about an extension of operative technique with the aid of electrosurgery, studies on the action of certain drugs introduced into the ventricular system, and the new syndrome which he was to describe as *pituitary basophilism*. When the time came for him to leave Boston he was happily privileged to see his life's work in surgery securely shouldered by pupils who had learned by apprenticeship his methods and artistry.

His decision to retire from active surgery, strengthened by a brief illness, came at the height of his accomplishments. A lesser man at this position in life would have found difficulty in finding a new outlet for his energies upon transplantation into a new environment. But he had always loved Connecticut, and Yale provided ideal conditions for the completion of some of the tasks he had long postponed. In the six brief years remaining he established with the aid of his associate, Dr. Louise Eisenhardt, a registry for brain tumors, the nucleus of which was his case-histories and specimens, and his now facile pen produced *From A Surgeon's Journal*, several papers on historical subjects and a memorable monograph on meningiomas.

Naturally a life of such endeavor and achievement was amply rewarded by innumerable honors from universities, scientific societies and governments. But appreciated perhaps more than these were the frequent visits from his pupils and the progress letters from patients on the anniversaries of their operations. These he answered promptly until the day of his fatal illness. Because of his qualities of leadership, which were drawn from an intimate knowledge of the great physicians of the past and his own rich experience, his counsel came to be sought by people in all walks of life. In the hearts of all who knew him his spirit still lives.

Kenneth Wade Thompson, M.D.

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# JOURNAL *of* The Connecticut State Medical Society

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VOL. III.

NOVEMBER, 1939

No. 11

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## Modes of Transmission in Poliomyelitis\*

JAMES D. TRASK, M.D.,  
New Haven, Conn.

The natural mode of transmission of poliomyelitis is unknown and, consequently, discussion of it is apt to be lengthy.

However, some remarks may be made which, I trust, are pertinent. Today the dogma of the nasal portal of infection seems to be adhered to less rigidly than was the case a few years ago. At any rate, authorities are ready to admit that besides the nose, there may be other avenues to the central nervous system and there is not much eagerness for chemical prophylaxis by the nasal drops. This may be considered an advance because the characteristic seasonal incidence of poliomyelitis does not fit well with the idea of a nasal disease.

The changing opinion about the portal of entry depends on a number of disconnected observations which concern: (1) the natural disease in man; (2) experimental poliomyelitis in man and in animals; and (3) the distribution of the virus in nature.

1. Lesions are not found in the olfactory bulbs in fatal human cases.

2. (a) The disease has been produced accidentally in man by the subcutaneous inoculation of vaccine; and

(b) Bulbar poliomyelitis occurs as a rare

but characteristic sequel 7 to 10 days after tonsilectomy.

(c) The experimental disease in monkeys may follow almost any method of administration of virus; intranasal instillation; intracutaneous, subcutaneous, intraperitoneal and intraneural inoculation. Especially important is the fact that monkeys may be infected by placing virus in their food. In America we were slow in believing this, because for oral infection it is necessary to use other monkeys than the common rhesus.

3. Finally, it is easier to detect virus in the stools than in the nasal washings of patients and convalescents; and it may persist in their stools for weeks after even mild and abortive poliomyelitis. The virus is highly resistant in stools and when kept in the refrigerator may remain active for 2½ months. Twice we have found virus in stools sent by mail from England. Dr. Paul, Dr. Culotta, Dr. Gard and myself have found virus in large amounts in sewage in the two recent epidemics in this country.

In reviewing the last finding one must admit that it may tell us nothing of how the virus is actually transmitted, but it demonstrates the existence of an enormous natural reservoir.

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# Hereditary Chorea: St. Anthony's Dance and Witchcraft in Colonial Connecticut\*†

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It is now nearly one hundred years since Waters<sup>1</sup> described correctly the features of chronic progressive, hereditary chorea with dementia in adults of certain families whose forefathers had moved from old colonial Connecticut to South-eastern New York State.

This contribution to American medicine in the year 1841 was not unearthed until almost seventy years had elapsed. In 1862,<sup>2</sup> Lyons cited a common belief in his community that this disease was an inherited curse, and his important record of its colonial genealogy slumbered in a medical journal for many years. Next, Huntington<sup>3</sup> reported it in 1872 "merely as a medical curiosity," but his description was vivid and thereafter European physicians called it Huntington's chorea on the assumption that he was the first physician to have mentioned its cardinal characteristics. But Huntington never dreamed of absolute priority so that it is certainly not his fault that his family name is now identified with this horrible American tragedy.

It must also be emphasized that MacLeod<sup>4</sup> of England was the first to establish degenerative brain pathology soon after Huntington's paper appeared; he described bi-lateral multiple lesions with atrophic changes in the convolutions of the brain, and inferred that the choreic motions were due to irritation of motor centers. It was his interpretation that this neuropathic taint in an individual started as an irritative process and ended in degenerative lesions.

## English Parent-Stems

Several years ago I reported a family-tree of this type of chorea showing direct transmission in seven generations and that the original parent stems had emigrated in 1630 from the Village of Bures<sup>5</sup> in East Anglia, England, to the Watertown Plantation, Massachusetts, on the historic

## Legend of Heredo-Familial Chorea

AUTHOR	WATERS	LYONS	HUNTINGTON
DATE	(1841)	(1863)	(1872)
TITLE	Chorea	Chr. Hereditary Chorea	Hereditary Chorea
LAY TERM	Magrums	Migrims	St. Anthony's Dance
SUPERSTITION		Curse: mocking crucifixion of Savior	Curse: persecution of Roger Williams, 1635
HEREDITY	Marked	Five consecutive generations	Direct trans-mission without skips
MENTALITY	Gradual dementia		Tendency to insanity and suicide
AGE	Adult		Adult
COURSE	Incurable	Incurable	Incurable

Winthrop-Saltonstall fleet. Back of the story of this family history existed the same secrecy, shame and misery which prevails in all such afflicted families here and abroad. A search into the lives of this early colonial group revealed a sorrowful march of victims to the scaffold, exile and social ostracism. Open official records, books in public libraries and medical records showed the choreographic dance of witches in the Bures family-tree to be a hereditary transmission, and that there were many collateral lines of chorea to prove it. My claim that these colonial parent-stems had emigrated from Bures has since been investigated and substantiated by MacDonald Critchley<sup>6</sup>, the recipient of a grant for that purpose from the British Medical Council. In urging the need of drastic sterilization and tightening of immigration laws and annual cost of hospitalizing these public charges, Critchley concludes, "One wonders just how many million dollars the gay lady of Bures with

\*From the clinical service of the Blythewood Sanitarium, Greenwich, Conn.

†Read at the 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

her three emigrant sons must have cost the State, or rather — the States!"

It is also opportune to mention that I recently had access to a letter written to Huntington<sup>7</sup> by Henry P. Hedges, a learned judge and historian born in 1816. This man knew the genealogy of chorea in Long Island. His parents had assured him that this "distasteful disease" had been passed on by an early settler in East Hampton, Long Island, whose name was Sarah Howell. The Muncey-Davenport<sup>8</sup> chart of about one-thousand choreics of this descent on file at Cold Spring's Harbor, Long Island, also reveals this woman's direct connection with this diabolical disease.

The Hedges letter establishes 1658 to have been the year when symptoms were cropping out in Sarah Howell, for the colonial records show that at that time she precipitated the arrest of Elizabeth Garlick<sup>9</sup> on a charge of practicing witchcraft on her body in East Hampton. Of all the crimes in Connecticut, the magic art of witches was treated as the most fiendish. In codifying it as a capital crime the lawmakers interpreted literally the 18th verse of the 2nd chapter of Exodus of the Mosaic Law and wrote, "If any man or woman be a witch, hath or consulteth with a familiar spirit, they shall be put to death." This accused witch was turned over to the authorities in the jurisdiction of Connecticut for capital trial by the General Court. Sarah Howell may have resorted to this means of self-defense to avoid the accusation of being a witch herself. She swore that Elizabeth Garlick annoyed and tortured her by pricking her body with pins, a possible rationalization for her uncontrollable choreic performances. She also insisted that she had seen a black form appear over her bed, and that the double-tongued witch threatened to tear her to pieces.

### The Role of Roger Williams

Huntington<sup>10</sup> had the advantage of learning something about tradition through his father and grandfather, both of whom had practiced medicine in New England. He cited a superstition prevalent among residents that this disease was a curse brought to Long Island by the descendant of the Bures group. Immediately after these emigrants had arrived, the celebrated Baptist Roger Williams, denounced all lawless settlers as unregenerates and the General Court was then



(The Ferrers Manor)

The Ferrers Manor, Bures, England: where members of choreic parent-stems resided before emigrating to New England in 1630. (Photo by Dr. Macdonal Critchley, London, England).

obliged to deny the oath of fidelity to all questionable characters. As a result of the violent attack by this firebrand, Nick Knap, of the Bures contingent, was not permitted to swear in court or pray in church, and for the rest of his life he was never made a freeman because he was a scoundrel. His brother, Willie Knap, had started out his early colonial career as a notorious lawless bully, for which he was kept under bond for years; he also was never voted a freeman. A review of the Massachusetts Bay, Middlesex County and Watertown records available in public libraries readily reveal that these two outcasts and certain of their children were responsible for a great deal of unsavory record on the black page of our early colonial history in America. The early accounts of the outcasts from Bures show disorderly conduct, theft, quackery, illicit sale of liquor, public prostitution, drunkenness, pauperism, religious dissension, family feuds and public denunciation of the Governor.

The relentless efforts of Roger Williams to reform the district left him without reliable friends,



and at the end of five years he escaped into the wilderness and founded the State of Rhode Island. The tradition of chorea visitation as a curse of the Lord upon the descendants of this notorious group is founded according to Huntington on belief that the bad characters from Bures had persecuted Roger Williams.

Huntington also knew that this type of chorea was called "St. Anthony's dance" by the Long Islanders. It still bears that name in certain localities where hot-beds of chorea have existed for the past three centuries. The dance is not to be confused with "St. Anthony's fire," a common term for erysipelas. The old English dialect word "magrums," meaning mad-staggers and fidgets, was also applied to the adult type of chorea. It is still used by residents of lower New England.

Some forty years ago, Gray<sup>11</sup> said that he knew a dozen towns near New York City where chorea families resided, but he was unable to elaborate on its history because the subject was shrouded in "great superstition," and "nursed as a dark secret." Osler<sup>12</sup> was compelled to dismiss a plan to study this form of chorea intensively because he was assured that members of these families would refuse to be interviewed.

Since the Middle Ages the pious St. Anthony has been depicted in various imaginative ways as tempted by witches and his body subjected to almost every conceivable form of sensual stimulation and tormentation by animal-demons despatched to his hermitage by his majesty, the devil. Out of this came the belief that Satan could move and agitate human parts and that his witches could transform themselves at will into animal shapes, such as a wolf or a black cat. Therefore, the weaving motions, jerking backward and forward of the head, peculiar grimacing and twitching, puckering lips, squirming shoulders, spasmodic movements of the chest and diaphragm, and involuntary jerking of the hands, feet and legs might readily be conceived as St. Anthony's dance by any superstitious person.

The Puritan days were dominated by the concept of diabolical existence as much as by Divine Existence, hence the Puritan fathers conceived a strange and undefined figure of Antichrist — half demon, half human — to show the hostile principles of Good and Evil. Elinor<sup>9</sup>, wife of Nick Knap, was believed to have been an example of such a transformation into an animal-

witch, and she was sentenced to death by hanging at Fairfield, Connecticut, in 1653. Before the execution she was kept on exhibition in the prison-house where crowds came daily to view her strange behavior and to harrass her unmercifully. Her body was examined for evidence of physical changes before and after she was cut down. The lengthy court records prove conclusively that this middle-aged woman was also suffering with advancing dementia since she had much difficulty with her memory; she could not recall her recent statements and con-

Rosy cries all  
day + all night  
and scratched  
the nurse and  
she is driving me  
out so she & I  
must move - Mary  
would not leave

(Handwriting)

Specimen of handwriting by direct descendant of choreic witch: showing jerky, distorted and sweeping gestures with the pen.

tinually contradicted herself, much to the exasperation of those who cross-questioned her. The Connecticut witchcraft law covered such evidence of dementia in choreics in article number seven: "Lastily, if ye party examined be unconstant and contrary to himself in his answers."

Mary Staples, once referred to as the sister of Elinor Knap stood before the mob at the scaffold to defend her kin and in a frenzy of fury and excitement she insisted on examining the nude

corpse and declared that there was no evidence of witches marks. Because of her defiance an attempt was made at once by Magistrate Sir Roger Ludlow to have her charged with witchcraft, but he was frustrated by a countercharge of slander.

### Cotton Mather's Interpretation

It is strange to note that in 1692, some forty years after the heroic defense of Elinor Knap, Mary Staples,<sup>9</sup> too, should be tried in the civil court in Fairfield on charges of witchcraft. More amazing is the simultaneous jailing of her daughter, Mary, wife of Josiah Harvey, and her granddaughter, Hannah Harvey. The Grand Jury considered it an abomination for these three to make a public spectacle of their witchcraft. It was lawful under article five in the Connecticut witchcraft law to hold under suspicion any son or daughter of a convicted witch on the authoritative reason that it was known "that a witch dying leaveth some of ye aforesaid heirs of her witchcraft."

The stupid accuser of Mary Staples described how her inexplicable acrobatic feats on and off horseback had dumbfounded him.

An hysterical adolescent, Catherine Branch, had mischievously declared that "the devil appeared in the shape" of this trio and three others: Sarah Miller, Elizabeth Clawson and Mercy Disborough. She clowned in public their physical contortions. At the trial the ministers made up their minds that this girl was guilty of "counterfeiting" their affliction and the six women were thereupon acquitted. Catherine had tried to ascertain from settlers the maiden name of Mary Staples, perhaps for the purpose of pointing out the blood relationship of witches who had been rounded up in Fairfield.

In building up the case of witchcraft the celebrated Puritan, Reverend Cotton Mather,<sup>13</sup> made the most of the sensational Elizabeth Knap, grandniece of Nick Knap, to confute his doubters. Because hysterical Elizabeth Knap imagined that she had been strangely convulsed by the devil, Cotton Mather argued from the pulpit at Boston that she was a witch who should have been hanged. Incidentally, her mother had returned to her motherland with the banished John Buttery. She was hanged because of her inability to fulfill a test to show that she could free herself of the devil by pacing until she dropped from exhaustion. Her name was Elizabeth Warne Knap.<sup>14</sup>



(Witch Scene)

Transformation of supposed witches into guises of animals.

In his interpretations of the various physical manifestations of witches, Cotton Mather spoke critically of bedeviled persons who "apishly" affected a "blasphemous imitation about our Saviour," while He suffered on the Cross. In his opinion, examples of this alleged wickedness were the adult choreics in early Colonial New England. As has already been stated, Lyons mentioned the legend that the forefathers of the choreics had been scoffers who dared to mock and ridicule the Saviour, and for daring to pantomime the agonizing motions so derisively that they and their descendants had become afflicted with a curse of facial characteristics and grotesque carriage attributed to witches. So terrifying to observers were the repulsive aspect and ferocious irritability of its victims, that parents in New England down to the present day teach their children to fear, hate and shun these "living examples of sin."

### Geographic Distribution

Evidently the persecution craze of these choreics was not confined to colonial New England, for Hattie<sup>15</sup> of Halifax reported several



generations of a French family of choreics who had emigrated from Montebelaire in the Alsace-Lorraine district to his country after the edict of the Nantes in 1690. In Western United States, Hamilton<sup>16</sup> discovered to his surprise years ago that the forbears of a number of choreics had emigrated from several European countries. It would be useless to try to trace the origin of this malady in the universe. Choreic families have flourished for years in Russia, Poland, Denmark, Sweden, Norway, The British Isles, Austria, Germany, France, Italy, Spain and South America. The surmise follows that this neuropathic taint must be of ancient origin if it is assumed that it started specifically from a single human being whose descendants had thereafter migrated slowly for centuries or even thousands of years throughout the inhabited world.

### Conclusions

Up to the present writing the family group which emigrated to the Watertown Plantation in Massachusetts from the Village of Bures in East Anglia, England, in the year 1630, is represented by an hereditary tree of twelve generations of choreics.

This form of adult chorea is a Mendelian dominant. It is not sex-linked, never skips a generation, has occurred in twins, and numerically 50 per-cent of an afflicted parent's offspring develop choreic manifestations in adult life.

It is impossible to foretell which child is choreabound, but it is now known that a backdrop of ingrained irascibility is an ominous personality trait. Members of these families who are aware of this menace in their heredity live in constant dread and often develop anxiety neuroses. After the appearance of choreiform movements many commit suicide.

Genealogies continue to be published in America and Europe from year to year and the consensus of opinion is that this taint will not cease unless rigid sterilization is recognized as the only true solution.

Witch-hunters did not put an end to this form of chorea by hanging and burning the afflicted mothers for the reason that they did not know that many of the children of accused witches would develop the disease in adult life. The only intelligent way to check this heredity is to warn all such choreics and their children against propagation.

The writer is indebted to Dr. Smith Ely Jelliffe, Dr. Charles Davenport and the late Frederick Peterson for access to genealogies.

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## Anorectal Tuberculosis\*†

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When the subject of tuberculosis is mentioned, it is natural and proper to think of pulmonary disease. We know that the usual manifestation of this infection is in the lungs, but we must not overlook the possibility of its affecting other organs and tissues. Primary tuberculosis of the anus or rectum is very rare. Most commonly, tuberculosis in these locations is secondary to Koch infection elsewhere in the body, usually the lungs.

Tuberculous lesions of the rectum, anus and perianal region are due to a progressively destructive infection by the tubercle bacillus. The anorectal lesions do not appear in very many clinical forms, and may be classified<sup>1</sup> as:

1. Perianal cutaneous tuberculosis, (a) Miliary tuberculosis, (b) Lupoid ulceration. 2. Anal ulcer or fissure. 3. Perirectal abscess and fistula.

The perianal cutaneous tuberculosis which we have encountered has been in conjunction with the other two classes of lesions. The anal ulcers which we have seen have varied in size and shape from small, superficial lesions to large, irregular shaped, undermined ulcers. The clinical course of these ulcers varies considerably. Some spread slowly while others extend rapidly in all directions and are very destructive. There is no

doubt in our minds that when these ulcers are neglected they may lead to abscess formation and eventually to fistula. Inasmuch as abscess is an intermediary condition preceding fistula, the two usually are grouped together. These latter conditions comprise about three-quarters of all tuberculous anorectal lesions. This tendency of anorectal tuberculosis to form fistulae has caused other investigators<sup>2</sup> to use the two terms interchangeably, and will be so used in this presentation. Conditions such as benign and malignant tumors, hemorrhoids, hypertrophied anal papillae, cryptitis,<sup>3</sup> prolapsus recti, colitis, pruritus ani, anorectal abscesses, and so forth are found with at least equal frequency in tuberculous as in non-tuberculous individuals.

There has existed a great deal of confusion concerning not only the relationship of anorectal infections and tuberculosis, but also between phthisis and the general run of anorectal conditions. Many prevalent ideas and procedures are based on misconceptions which antedate the use of spinal and sacral analgesia, as well as the modern methods for the treatment of pulmonary tuberculosis such as artificial pneumothorax, scaleniotomy, phrenicectomy, and so forth.

TABLE 1

Sex Distribution of Simple Fistula in Ano

Observers	Hospitals	Year Reported	No. of Fistulae or Abscesses	Per Cent. in Males
N. Morgan (3)	St. Mark's, London.....	1928	196	72
Buie (4)	Mayo Clinic.....	1931	1000	58.9
Tung (5)	Pekin Union Med. C.....	1927	150	84
Authors	Brooklyn Hospital.....	1932	269	70

\*From the Tuberculosis Division, The Kingston Avenue Hospital, Doctor Foster Murray, Director of the Tuberculosis Service; and from the Surgical Service, Division of Proctology, The Brooklyn Hospital, Doctor Ernest K. Tanner, Chief Attending Surgeon.

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## Sex

Both specific and non-specific fistula in ano are more commonly found in males than in females. No satisfactory explanation of this has been advanced. As shown in Table 1, the statistics of four general hospitals located in different parts of the world, bear out the above statement.

This fact is further emphasized in Table 2.

TABLE 2

## Sex Distribution of Anorectal Tuberculosis

Observers	Per Cent in Males
Chisholm and Gauss (2).....	75
Melchior (6).....	92
Clarke (7).....	89
Fansler (8).....	72
Martin (9).....	70
Gabriel (10).....	83

TABLE 3

## Incidence of Simple Fistula in General Hospitals

Observers	Hospitals	Year	No. of Admissions	No. of Fistulae	Per cent. of Admissions
Leslie (11)	Vancouver General	1924	4648	24	0.52
Leslie (11)	Massachusetts General	1924	4351	30	0.69
Authors	Brooklyn Hospital	1927-36	80643	559	0.69

## Incidence

As is demonstrated in Table 3, fistulae in ano of whatever cause comprise less than 0.7 per cent. of the total number of admissions in three representative general hospitals. This fact is brought to your attention for purposes of comparison with the incidence of tuberculous fistula in ano among phthisic patients.

It has been variously estimated (Table 4) that between two and sixty-one per cent of all anal fistulae are tuberculous in character. There are two main reasons for this great variation in the reported incidence. The first reason is the great variety of criteria in arriving at a diagnosis of anorectal tuberculosis. Whereas some workers insist upon guinea-pig inoculations, others maintain that the lesions are sufficiently characteristic to permit diagnosis on clinical appearance alone. The figures of those who even at this late date maintain that all fistulae are tuberculous need not be taken seriously. Secondly, the fact that this disease is found predominantly in males results in a marked difference in the statistics obtained in hospitals devoted entirely to males as compared to hospitals which admit both sexes, or are devoted entirely to females.

Fistula in Ano and Pulmonary Tuberculosis: After a fairly extensive study of the literature and from personal clinical experience, Chisholm<sup>2</sup> reached the conclusion that between three and five per cent. of all persons with pulmonary tuberculosis develop tuberculous anorectal com-

plications. Table 5 shows that these figures vary from one to seven per cent., but three to five per cent. is nearer the average. The higher incidence is found among institutions admitting males only, as well as in municipal sanatoria whose patients are obtained from the lower economic and social strata. Another important consideration is that many of these anorectal lesions are overlooked because proctologic surveys are not routinely employed.

## Anorectal Examinations in Tuberculous Patients

This study is based on our experiences with anorectal tuberculosis obtained in the Tuberculosis Division of the Kingston Avenue Hospital, the Brooklyn Hospital, and private practice. We will confine ourselves mainly to the detailed analysis of the cases seen at the Kingston Avenue Hospital.

There were six hundred and twelve admissions to the Tuberculosis Division of the Kingston Avenue Hospital during the period 1933-1937. In addition to the usual physical examination, our plans call for a complete routine proctologic survey on all new admissions. Three hundred and fifty-seven such examinations were performed, the remaining two hundred and fifty-five were either re-admissions, or were too ill to be examined, or expired a short time after entrance into the hospital. Of the three hundred and fifty-seven patients who were examined, two hundred and twenty-seven (63.6 per cent)

TABLE 4

Observer	Location	Year	No. of Cases Observed	Per Cent of Fistulae Considered Tuberculous	Criteria for Diagnosis
Konig (12)	Germany	1889		50 plus	The presence of phthisis at any time
Tuttle (13)	United States	1902		50	
Lanz (14)	Germany	1916		Few	
Volkman (15)	Germany			50 plus	Pathological picture
DeQuervain (16)				50 plus	
Frey (17)	Germany	1914	72	7	
Goz (18)	Munich, Germany	1917	95	45	Development of phthisis during seventeen years following operation
Melchior (6)	Kuttner Clinic, Breslau	1917	132	61	
Thoss (19)	Munich, Germany	1920		5.5	
Harrison	England			11.9	Microscopical findings
Cripps (20)				10 to 15	
Swinford	England			12	
Edwards (21)					Microscopical findings, T. B. in sections
Gabriel (10)	St. Mark's Hospital, London	1921	45	9	
			30	20	
Dudley (22)		1921	90	2.2	Injection of guinea pigs
Gant (23)	New York City	1921	5000	10 minus	
Fansler (24)	Minneapolis, Minn.	1925		2 to 3	Microscopical findings and inoculation of guinea pigs
Archibold (25)	Canada	1926		33	
Leslie (11)	Vancouver General Hospital, Canada	1926		21	The presence of associated pulmonic lesions
Leslie (11)	Massachusetts General Hospital, Boston	1926	30	None	
Tung (5)	Pekin Union General Hosp.	1927	102	25.5	Microscopical picture
Naunton	St. Mark's Hospital, London	1928	100	9	
Morgan (3)					
Miles (26)	London	1931		14	Microscopical picture
Buie (4)	Mayo Clinic, Rochester, Minn.	1931	1000	2.2	
				5.5	
Martin (9)	Private Practice, Chicago, Ill.	1933		3 to 5	Microscopical picture
Berry (27)	Presbyterian Hospital, New York City	1933	160	10.6	
Berry (27)	Bellevue Hospital, New York City	1933	202	18.3	

showed evidence of anorectal disease, while no disease was found in the remaining one hundred and thirty (36.4 per cent). The conditions which were found are shown in Table Six, and it will be noted that two hundred and seventy-six lesions were found in the two hundred and twenty-seven patients, i.e., some patients had more than one lesion. The literature had led us to expect a higher incidence of rectal ulcers than

the two found by us. It may be stated, in this connection, that Granet<sup>36</sup> reports the discovery of only two cases with rectal ulcers in one hundred and fifty successively proctoscoped tuberculous patients. His finding approximates ours.

We found tuberculous anorectal lesions in forty-two of the three hundred and fifty-seven patients. Thus, our incidence of anorectal tuberculosis among tuberculous patients is 11.7



TABLE 5 — Anorectal Fistula as a Complication of Pulmonary Tuberculosis

Observer	Year of Report	Number Observed	Source	Per Cent of Patients	Remarks
Henigar (28)	1909	4160	Trudeau Sanatorium	1.1	
Powell and Hartley (29)	1921	263		1.6	Early Cases
Hartmann (30)	1921	626	Public Hospitals	4.9	
Rickmann (31)	1922	489	Private Sanatorium	2.6	
Clarke (7)	1924	185	City of London Hospital of Heart and Lungs	6.0	Males
Leslie (11)	1926		Jordan Memorial Sanatorium	1.5	Mainly Early Cases
Stewart (32)	1926	700	Calydor Sanatorium	2.0	
		167	Traquille Sanatorium	4.2	
		850	Manitoba Sanatorium	2.2	
Petter and Fansler (1)	1931	1500	Glen Lake Sanatorium	6.0	Early Cases
(from records)					
Petter and Fansler (33)	1931	190	Glen Lake Sanatorium	7.4	Males Early Cases
Fishberg (34)	1932			2.0	
C. L. Martin (9)	1933	10000	Chicago Municipal Sanatorium	7.0	Early Cases
Chisholm (2)	1933		National Jewish Home	3.0 to 5.0	
Lockhart-Mummery (35)	1934		Brompton Hospital for Consumption	4.0	
Authors	1938	357	Kingston Avenue Hospital	11.7	Males All stages of pulmonary TB

TABLE 6

**Anorectal Conditions  
Found in 227 Out of 357 Patients Examined**

Condition	Number
Hemorrhoids.....	128
Tuberculous fistula in ano.....	30
Hypertrophied anal papillae.....	29
Cryptitis.....	16
Proctitis (simple).....	15
Anal fissure (simple).....	13
Colitis (simple).....	11
Tuberculous anal ulcer.....	11
Pruritus ani.....	8
Rectal polyp.....	4
Perianal abscess.....	3
Ischiorectal abscess.....	3
Tuberculous rectal ulcer.....	2
Tuberculoma.....	2
Prolapsus recti.....	1
Total.....	276

per cent. This figure is higher than that reported by other observers, but the apparent discrepancy can be explained by several factors. This group of patients consisted entirely of males; the majority had advanced pulmonary disease; they were from the lower economic and social strata; and each case received a scrutinizing proctologic examination. Although exact figures are difficult to obtain, it is evident that compared with the 0.7 per cent. incidence in the general population, fistula in ano is at least ten times more frequent among tuberculous individuals. The reason for this may be ascribed to diminished or absence of immunity in these patients, the presence of tubercle bacilli in addition to the bacterial flora usually found in that region, and the increased likelihood of anorectal trauma due to constipation, enemata, introduction of thermometers and so forth, resulting in portals of infection.

#### Diagnosis

There has been considerable controversy as to the methods of arriving at a diagnosis. We most emphatically do not subscribe to the statements of many writers such as Volkman,<sup>15</sup>

Konig,<sup>12</sup> Melchior,<sup>6</sup> and Goz<sup>18</sup> that the majority of all rectal fistulae are tuberculous in character. Nor do the majority of those who have had considerable experience with anorectal tuberculosis agree with these writers. Any one who has seen a substantial number of proven tuberculous fistulae with their characteristic changes, should be able to distinguish them easily from ordinary fistulae. Perhaps the difficulty has been that these characteristics cannot be described satisfactorily in printed words or by word of mouth. It is our considered opinion that while guinea-pig inoculation has the advantage of considerable accuracy, the elaborateness of the method makes its use possible only to those who are properly equipped. Chisholm,<sup>2</sup> Fansler,<sup>1</sup> and Gabriel<sup>10</sup> depend on guinea-pig inoculation for a diagnosis. Others, such as Sweany,<sup>37</sup> state that the diagnosis depends on histopathological findings because the bacteriological findings are indefinite and of no value. It is conceivable that swallowed tubercle bacilli appearing in the stool and contaminating, but not actually infecting, a simple anorectal lesion may give false bacteriological information. On the other hand, the absence of tubercle bacilli in tissue sections does not exclude the possibility of tuberculous infection, just as the absence of tubercle bacilli in the sputum does not exclude the possibility of pulmonary tuberculosis. In the diagnosis of our cases we have been governed by the clinical appearance of the lesions and the microscopic findings. The clinical picture in anorectal tuberculosis is so characteristic that on many occasions, in private and hospital practice, we have been able to discover the presence of otherwise unsuspected pulmonary tuberculosis from the appearance of the anorectal lesion. The diagnosis, in these cases, has been confirmed by x-ray of the lungs and sputum examination. Some of these anorectal lesions may reach a stage where they may be confused with malignancy, syphilis, and venereal lymphogranuloma. Biopsy suffices to distinguish them from carcinoma; the Wassermann reaction, or the luetic therapeutic test when indicated, will assist in excluding syphilis as the cause; and the Frei test will differentiate these cases from venereal lymphogranuloma. Conversely, a positive guinea-pig inoculation will help to rule out malignancy and the anorectal aspect of venereal lymphogranuloma unless a combination of these diseases exists. Although

such complicated cases have been reported, they are very rare.

### Summary of Forty-Two Cases

The ages of our 42 cases ranged from 17 to 55 years, the average age being 33 years. Eighteen were less than 30 years old, and only nine were over 40. Thirty-seven (88 per cent) of the patients had advanced or extensive phthisis.

In nine of our cases of anorectal tuberculosis there was a history that the pulmonary involvement was not discovered until several weeks to seventeen years after the development of the anorectal lesions. At one time such cases were considered primary anorectal tuberculosis and it was thought that the lungs became secondarily involved. We do not believe that there are any present-day investigators who hold to that theory. The general opinion is that primary anorectal tuberculosis is extremely rare, and that the pulmonary involvement in these cases has been overlooked, either because its presence has not been suspected or through inexperienced examination. Also, it is likely that some of these anorectal infections were not tuberculous at the time, but became secondarily infected with the tubercle bacillus after establishment of the pulmonary disease. It is not unusual to have patients with proctologic conditions admit that their ailments have been of five or more years' standing. If one of these patients contract pulmonary tuberculosis, their anorectal condition may become secondarily infected.

Our observations lead us to believe that the portal of entry for the tubercle bacillus is the lymphoid tissue about the anorectal line in the region of the crypts of Morgagni. Six of our patients developed fistulae during their stay in the hospital. Examination shortly prior to the development of the fistulae in these cases revealed signs of irritation and infection in the anorectal region such as sphincter spasm, tender induration, inflamed and distended crypts, and inflamed internal hemorrhoids. In spite of close observation and care, these cases went right on to abscess and finally, fistula formation.

The tuberculous lesions encountered in the anus and rectum among the forty-two patients are shown in Table Seven.

As these abscesses are usually intermediary conditions preceding the fistulae, the two were placed in the same group in Table Seven. These



TABLE 7

## Relative Incidence of the Various Tuberculous Anorectal Conditions in 42 Patients

Condition	Number	Per cent. of all Anorectal T. B. Lesions
Fistula or abscess.....	36	70.6
Anal ulcer.....	11	21.6
Rectal ulcer.....	2	3.9
Tuberculoma.....	2	3.9

lesions comprise about three-quarters of all tuberculous anorectal conditions.

The stages through which a tuberculous anorectal fistula evolves are usually congestion, indurated swelling of tissues, and softening with the formation of an abscess. After the disease process has become established, the condition progresses slowly as compared to ordinary pyogenic lesions. When the wall of this abscess breaks down, a sinus or so-called blind fistula is formed. When a secondary opening forms, a complete fistula results. A sinus or fistula may become an ulcer through a gradual, progressive destruction of the edges of an opening or openings. The removal of tissue connecting the two openings of a tuberculous fistula will likewise transform a fistula into an anal ulcer. All anal ulcers do not form in this manner. The invasion of a simple anal fissure by the tubercle bacillus may result in a tuberculous anal ulcer.

The tuberculous fistulae in ano which we studied presented definite characteristics which distinguish them from simple fistulae. Their external openings were frequently multiple. The margins of the openings were irregular, flabby, moth-eaten in appearance, undermined, somewhat edematous, and purplish in color. The subcutaneous tracts were easily palpable. They were easily probed because of their comparative wide lumina and large, flabby openings. The internal opening of these fistulae was often palpable as a wide, shallow depression in the anorectal line. Profuse discharge was at times found, but more often the discharge was scant and thin. Scrapings for examination were taken from the edematous granulations which lined the tracts.

The tuberculous anal ulcers which we observed were usually wide, shallow, non-indurated, and close to the anal verge. Their edges were undermined and overhanging, and their bases were

covered with edematous, sluggish granulation tissue. Some showed a tendency to spread by extension towards the anus and rectum, as well as in other directions, while others appeared to respond to local treatment and became inactive and covered with epithelium. Close inspection of some of the more persistent ulcers revealed small openings at their bases. Probing of these openings demonstrated abscesses situated underneath the floor of the ulcers.

Twenty-five of our 42 cases had associated anorectal conditions. Internal hemorrhoids were noted in 21. Hypertrophied anal papillae came next in frequency, being present in eight. Perianal eczema with pruritus ani was prominent in seven. Four had a moderate proctitis of the terminal rectum, while the proctitis in another case was quite marked. There were two patients with anal polypi, and four with tuberculous enteritis.

In order of their frequency, the following were the symptoms which our forty-two patients presented: Anorectal discharge, pruritus ani, anorectal bleeding, and pain. That anorectal tuberculosis may be present without giving rise to any symptoms was emphatically brought to our attention by eleven patients with tuberculous anorectal lesions, who offered no anorectal complaints. Routine proctologic examinations made possible their discovery. In fifteen patients, however, there was a history of pre-existing local abscess or fistula. Of these, seven had experienced a spontaneous rupture of an abscess, another seven had had their abscesses incised, and one had had an unsuccessful fistulectomy. As would be expected, the symptoms were most prominent during the abscess stage, at which time swelling, pain, rise in temperature, and toxic symptoms would be most likely to be present.

One of the most significant findings in the study of these patients was that the post-operative course in tuberculous patients with negative sputa was short, comfortable and favorable as in non-tuberculous patients, i.e., an average of fifty days. In patients with positive sputa, however, the average length of time required for healing was one hundred and one-half days. These findings have convinced us that the optimum time for the institution of operative measures is when the patient's sputum is negative, or when the pulmonary disease is in

a quiescent phase with the number and concentration of the tubercle bacilli greatly diminished. Further, these findings have strengthened our belief that the swallowing of positive sputum is an important factor in the production of anorectal tuberculosis.

### Treatment

In considering the treatment of an anorectal lesion in a patient with pulmonary tuberculosis, the non-tuberculous or tuberculous nature of the local condition must be determined. Non-tuberculous anorectal conditions such as enumerated above, should not be operated upon in the presence of active pulmonary tuberculosis with positive sputum unless there is great urgency. Internal hemorrhoids can be treated by injection therapy, and the other conditions should be treated by conservative or palliative measures whenever possible. Palliative measures, as well as scrupulous local cleanliness and attention to the bowels, will do much to prevent local infection with the tubercle bacillus.

Conservative or medical management includes the general care of the patients, as well as local treatment of the lesion. Local conservative therapy consists in keeping the parts clean, the use of ultraviolet light, and the application of various medicaments. This treatment accomplishes little more than to prepare the patient for operation. Radical surgical measures should be reserved for those patients whose general condition permits of such treatment. Palliative surgery is justifiable if it adds to the comfort of the patient, and frequently it will help to build up the resistance so that more radical surgery can be performed at a later date. It should be kept in mind that these patients are suffering from a constitutional disease. If surgical treatment of their anorectal lesions is to be instituted, each operation should be planned to suit the degree of pulmonary involvement and the condition of the sputum in each particular case. Frequently, patients with advanced pulmonary tuberculosis will tolerate anorectal operations done in multiple stages where operation in one stage would be contraindicated or impossible.

Most writers emphasize the use of the cautery and electro-surgery in the surgical treatment of these cases. In the beginning we, too, used the cautery, as well as the diathermy knife, but found that our patients were not made more comfortable, and that sloughing, ugly, slow or non-healing wounds resulted. The main reason

for the use of the cautery was the supposed sealing of the lymphatics to prevent the spread of the disease. It has not been proven to our satisfaction that the lymphatics remain sealed for very long. We, therefore, instituted the same surgical measures in these cases as we used ordinarily in anorectal surgery, with the difference that our excisions included a little of the surrounding healthy tissues, thereby disturbing the local disease as little as possible.

Cleaner and quicker-healing wounds resulted, and thus far we have no reason to believe that the disease has been caused to spread along the lymphatics through these measures. On the contrary, these patients showed remarkable local and constitutional improvement. What at one time was attributed to spread from the local disease may have been caused by exacerbation of pulmonary involvement caused by general anesthesia. We have employed spinal analgesia, using 25 to 50 mgm. of procaine hydrochloride in all our operative work. The analgesia has been most satisfactory, and not a single complication of any kind has been encountered. In the more extensive lesions, multiple-stage operations were planned, and in some cases temporary colostomies were made so as to short circuit the fecal stream, re-establishing the continuity of the bowel after healing of the lesion had taken place.

The postoperative care of these patients is of prime importance. A most brilliantly performed operation will invariably result in failure if the postoperative care is inadequate. These patients require daily dressing, keeping in mind the principle that the wounds are to be made to heal from the bottom up. Bridging can be prevented by swabbing the wounds with sterile applicators or applicators soaked with mild antiseptics. Although we have not used zinc peroxide for a sufficient length of time or on a sufficient number of cases to arrive at definite conclusions, we feel that the slow liberation of oxygen by this medication should be useful. Ultraviolet light is of value, but there is some difficulty in having the rays reach the innermost recesses of some of these wounds.

### Conclusions

1. Fistula and abscess are about ten times more common among the tuberculous than among the non-tuberculous. They occur with



greater frequency in the young than in the old, and among advanced than among the early cases of pulmonary tuberculosis; more frequently in public hospitals than in private sanatoria, or private practice. They are three to four times as common in tuberculous males as in females.

2. Nearly all fistulae, abscesses and ulcers in individuals with active tuberculosis are in themselves tuberculous in character as a result of secondary infection with the Koch bacillus. The tuberculous character may be determined by the clinical and the microscopical appearance of the lesion, as well as by the inoculation of guinea-pigs.

3. Frequently, tuberculous patients with fistulae not only neglect to mention that they are harboring such a lesion, but they also deny having any symptoms. Hence the importance of routine proctologic examinations of tuberculous patients.

4. As a rule, under spinal analgesia tuberculous patients prove to be good operative risks for the ordinary procedures used in cases of anorectal tuberculosis. The technique used need not deviate greatly from that employed in non-tuberculous patients.

5. In patients with positive sputa, the prognosis as to complete healing is usually good, although convalescence is often protracted. In patients with negative sputa, the wounds heal about as quickly as in non-tuberculous patients.

6. Operations for anorectal tuberculosis serve to eliminate foci of infection and to add to the comfort of the patient, thus enhancing the efficacy of the general treatment of pulmonary tuberculosis.

7. Four years' work in any field of medicine or surgery should enable one to determine whether the problems encountered have been met properly. A review of such work can be a source of satisfaction, or it may lead one to consider ways of improvement. We feel that anorectal lesions in tuberculous individuals present serious problems, but, in general, their response to treatment is gratifying.

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(Concluded on Page 628)

# The Provocative Diathermy in Conjunction With the Sedimentation Rate—

## A More Accurate Guide in Determining the Best Time to Operate in Elective Pelvic Surgery\*

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The rate of the red blood sedimentation is a simple determination of proven diagnostic and prognostic value. Justly has it come to be regarded by gynecologists as a measure of the intensity as well as the progress of the disease in pelvic inflammatory conditions. Polak of New York had repeatedly emphasized this test as the measure of the amount of inflammation which still existed in cases of pelvic inflammatory disease. Where the rate was significantly increased, in non-urgent cases, he advised against operation.

Just as the sedimentation test has proven its worth in diagnosis and prognosis, medical diathermy has established its therapeutic value in all conditions where deep seated heat would be of aid. Only occasionally, however, has diathermy been utilized as a diagnostic means. Kovacs describes the use of provocative diathermy in old osteomyelitic infections to indicate by the presence or absence of irritative symptoms (fever, pain) following the application, as to whether a lurking disease process still were present.

The purpose of this paper is to correlate the two, the provocative diathermy with the sedimentation rate, in order to furnish a still more sensitive gauge in determining the best time to operate in cases of non-urgent pelvic surgery, than is offered by the sedimentation test alone. To do so, I shall briefly review the basic principles underlying the sedimentation test and medical diathermy, as they are utilized in our clinic.

The accepted principle of the blood sedimentation test is based upon the fact that in blood

containing an anticoagulant the cells settle, leaving a clear plasma. The sedimentation is more rapid in disease than in health. The most favored explanation of this phenomenon is that tissue breakdown releases an increased amount of fibrinogen which induces clumping of the cells. The clumps settle more rapidly than the single cells.

To perform the test we have used the Cutler tube, which is five millimeters in diameter, marked in millimeters, beginning with zero at the 1 cc. level to fifty millimeters at the bottom. Drawing in exactly 0.1 cc. of sterile three per cent sodium citrate into a syringe and then filling up to the 1 cc. mark with blood from the prominent vein in the elbow, the solution is mixed by tilting. If necessary, a longer needle is placed on the syringe and the sedimentation tube is filled, after placing the point of the needle at the bottom of the tube.

Readings of the cell drop are taken on the half hour and on the hour. Normally, there occurs a drop of from 2 to 15 mm. in one hour. A slow rate eliminates infection as a cause of the symptoms. An increased rate, apart from pregnancy, is always a sign of serious disease, usually active in inflammation or well advanced malignancy. In the acute inflammatory conditions the sedimentation rate is usually directly proportional to the extent and severity of the inflammation. A reading of 18 mm. in thirty minutes is usually found in the presence of acute pelvic abscess. A patient showing a sedimentation of over 18 mm. in one hour, if operated upon for pelvic inflammation, may have a stormy

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convalescence. Readings are valueless after the third month of pregnancy and for the first two weeks of the puerperium, as the high reading cannot be attributed to an infection. In anemias the sedimentation rate is increased in direct proportion to the severity of the condition. Readings for one week following a surgical operation show an increased rate due to the tissue trauma and absorption.

The provocative diathermy, as we have used it, has been abdomino-sacral in every case, with the duration of the treatment being twenty minutes. It can be reasonably expected that all local diathermy treatments result in an acceleration of local metabolic processes through stimulation of cell activity and hyperemia. The physiological effects produced by medical diathermy are increased circulation, sensory and motor nerve sedation, and bactericidal action. The therapeutic uses of the diathermy treatment are relief of pain and spasm and the promotion of nutrition and absorption.

It is due to this fact, that medical diathermy promotes absorption, that a sedimentation test performed one hour after the provocative diathermy treatment may indicate the presence of infection that is not quiescent and so warn against operation that may result in a stormy post-operative course. In our clinic, on the day previous to operation, all cases of non-urgent pelvic inflammatory disease are given the provocative diathermy. One to two hours later, a blood sedimentation test is performed. If the rate has increased significantly over the previous rate or is over 18 mm. for the hour, operation is postponed. In such a case the provocative diathermy followed by the sedimentation test is repeated at two day intervals, until such time when no marked increase in the rate is observed. Then, and only then, is operation performed.

For more than three years that this practice has been adopted in our clinic there has been a decrease in the morbidity as well as a decline in

the number of cases of stormy convalescence following elective pelvic operations.

### Summary

1. A brief description of the sedimentation test and its utilization as a diagnostic aid is presented.
2. Medical diathermy, as provocative diathermy, is discussed from the standpoint of diagnosis rather than therapeutics.
3. Ease of performing both procedures is described.
4. The provocative diathermy with the sedimentation test acts as a more sensitive gauge in determining the time of operation in non-urgent pelvic inflammation than the sedimentation rate alone.

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### THE PARAFFIN BATH

Walter J. Zeiter, M.D., in the August issue of *Archives of Physical Therapy* presents a very convincing article on the Clinical Application of the Paraffin Bath. The use of paraffin is advocated whenever a local form of heat is desired. The author claims excellent results in the treatment of arthritis, effective also in the treatment of stiff joints following lacerations or infections, of scars restricting motion of joints and tendons, of joints involved secondary to nerve lesions as in sprains and contusions, and in the treatment of fibrositis of the lumbar region. It is simple to operate and maintain, cheap to use and available for use in the home.

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# The Diagnosis of Bronchiogenic Carcinoma\*

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As with most types of malignancy, the successful surgical treatment of bronchiogenic carcinoma demands an early diagnosis. The recorded literature and our own experience indicate that radiation therapy in its various forms is rarely, and perhaps never, curative. At best, palliation with or without prolongation of life beyond the expected limits of the disease process is the result. As long as we do not understand the true nature of malignancy and its specific control, the burden falls on surgery to attempt progress by extirpative therapy of this fatal disease. Technical developments in thoracic surgery have made the removal of a lobe or an entire lung increasingly feasible and safe. Successful surgical results will depend therefore on the general practitioner who first sees the great majority of middle-aged patients with pulmonary symptoms. The practitioner must make the initial tentative diagnosis of malignancy and start the patient on the road toward the indicated diagnostic procedures.

Carcinoma of the bronchus must be suspected in any patient who begins to cough, to raise sputum (especially blood-streaked), to have ill-defined pain in the chest or shoulders, or to lose weight and strength. Any of these symptoms may mean carcinoma in the bronchial tree, especially if the sputum when present is negative for acid-fast organisms on repeated examination. Age is of diagnostic importance. In a consecutive group of 24 verified cases at New Haven Hospital, 14 were between 40 and 60 years old, but one notes with emphasis that two were under 30 years of age.

The tendency in any rapidly developing field of therapy is toward technical, and increasingly complicated, diagnostic procedures; procedures which require the services of a so-called specialist not infrequently to the neglect of simpler methods which may be utilized successfully in a given case. For example, of the 24 proven cases of

bronchiogenic carcinoma seen by us in a two-year period, 11 were diagnosed by a simple procedure, namely, biopsy of metastatic lymph gland deposits in the supraclavicular, (9 cases) or axillary regions (2 cases). Occasionally, as in one case, a serous or serosanguinous pleural exudate over the affected lung may be aspirated with a needle, the fluid centrifuged at high speed, the sediment obtained for sectioning, and unmistakable tumor cells found by microscopic examination of the fixed sediment.

When there is a history of pain located over the back, pelvis or the long bones a well-directed roentgen study may reveal metastatic deposits in bone, the biopsy of which may be surgically feasible. Symptoms referable to an expanding lesion in the central nervous system, even without respiratory symptoms, warrant roentgen examination of the chest, a point well known to most neurologists.

The introduction of an artificial pneumothorax on the affected side, and a visual search of the pleural membranes by a special endoscopic instrument known as the thoracoscope (which is inserted through an intercostal space by means of a suitable cannula) may reveal metastatic deposits on the parietal pleura. In two of these 24 cases we have successfully biopsied such lesions.

Unhappily, all of the above described procedures, while making an absolute diagnosis possible, have also immediately labelled the patient as a hopelessly advanced and an inoperable case. The chest surgeon needs, the attending physician desires, and the patient must have earlier diagnostic methods to find lesions in a localized and favorable stage. The diagnostic problem in the early cases is not always easily solved. The procedure which offers the greatest hope of diagnosis at an early stage is bronchoscopy. In our cases 60% had lesions so situated in the larger (stem) bronchi that tissue could be removed with the biopsy forceps and a micro-

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scopic diagnosis made. Unfortunately, in the remainder the initial tumor was so peripherally located that it could not be visualized with any endoscopic instrument at present available. Therefore, in cases of persistent infiltrative pulmonary lesion, when specific tuberculous or non-specific pyogenic infections such as abscess or bronchiectasis have been excluded and the criteria of operability have been fulfilled according to the above outline (i.e. absence of regionary lymph node metastases, absence of pleural or mediastinal involvement by thoracoscopy, absence of bone or cerebral metastases), then the patient should have the benefit of exploratory thoracotomy. No one hesitates now to advise exploratory laparotomy when diagnostic problems exist with respect to malignant disease of the abdominal viscera. It has been demonstrated that exploratory thoracotomy performed by an adequately trained operator and aided by skillful anesthesia involves only slight morbidity and very little risk to the patient's life. Direct palpation and inspection of the lung may settle the diagnosis, the question of operability and indicate the appropriate treatment.

Certain cases of bronchiogenic carcinoma will continue to present themselves for their first medical care in an advanced inoperable state, with little or no symptomatology. If, however, the possibilities inherent in the above diagnostic procedures are borne in mind, there will appear more and more frequently early cases suitable for surgery and fewer hopelessly advanced lesions in patients so many of whom have received well intentioned but ill-advised palliative treatment while the lesion progressed to an inoperable stage.



### FLOWERS AND PILLS

According to California and Western Medicine the University of California Medical Center now prescribes a bouquet of flowers once a week to every patient in both hospital and public clinics.

## EPILEPSY

### A Reportable Disease.

With the increase of mechanization in this century, epilepsy has taken on a new significance in the social order. Before the time of the automobile the epileptic was seldom a menace to others and but infrequently injured himself. Now that everyone is an automobile driver, real or potential, the situation is vastly changed. It has become incumbent upon practitioners of medicine to protect the victim of a convulsive state from himself as well as to protect the interest of others who might be the victims of his acts.

It is an interesting phenomenon, that patients who have epilepsy will deny the presence of the disorder, even to the point of swearing falsely in an application for a driver's license. When one questions them closely as to the reason for their denying the disease in their application, they give some such reply as "mine is not epilepsy, it is stomach disorder." This a perfectly understandable reaction because of the odium which is usually attached to the malady by uninformed persons, and the repulsiveness of the convulsive attacks when viewed by the uninitiated. One cannot but have the greatest of sympathy for these unfortunate victims; on the other hand their own safety must be safeguarded as well as that of others.

The Act recently signed by the Governor, will go into effect September 3. It will thereupon become the duty of every practicing physician to report every patient who has epilepsy to the local health officer, who will send the report to the State Department of Public Health, and it will, of course, be made available for the Motor Vehicle Department. Failure to report will constitute a misdemeanor.

*Cal. and West. Med., Sept. 1939*

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(SEE PAGE 2.)

## Resection of the Colon

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There are various ways of performing resection of the colon and the purpose of this paper is to describe and evaluate some of them. There are three main types, the open, the closed or the obstructive section. Whether multiple stage procedures should be used and the type of a nastomosis end to end, end to side or side to side side, must be decided.

The right side of the colon includes the cecum, ascending colon, hepatic flexure and that portion of the transverse colon to the right of the middle colic artery. The remainder of the colon down to the recto-sigmoid junction is described as the left side.

Carcinoma, obstructing diverticulitis, colitis, and tuberculosis are the most common diseases requiring resection of the colon.

In the open resection the diseased bowel is removed and anastomosis performed either by end to end, end to side, or side to side methods. The intestine is opened and the anastomosis is therefore performed in an infected field. However, by proper precaution the amount of soiling is reduced to a minimum and the chief danger is from interference with the blood supply. Care must be used in resecting the mesentery to preserve vital blood vessels, and too tight suturing should be avoided, although haemostasis must be carefully done. Two layers of No. 1 chronic catgut on intestinal needles are used, although some prefer silk for the serosal layer. It is only necessary to use interrupted sutures to approximate the serosa.

Attempts to prevent soiling have resulted in the closed or aseptic methods, of which the Parker-Kerr is perhaps the best. The bowel is resected with a cautery and the ends are inverted aseptically over clamps by means of a basting suture. The clamps are withdrawn and then the ends are united, usually by the end to end method and the basting sutures are withdrawn. The lumen is established by manipulation with the fingers. This method may be used, end to side, or side to side, as well. It is necessary to

perform an ileostomy if done in one stage, to prevent gas pressure on the line of suture. Others use clamp methods as devised by Rankin and Furniss. There are certain difficulties, as interference with blood supply and perforation of the lumen with sutures. It is doubtful if there is such a thing as an aseptic resection because there is usually some leakage. However, in skilled hands, it is doubtless more aseptic than the open method, although those who favor the latter state that the danger of soiling is slight and that the real hazard is from interference with the blood supply.

The introduction of decompression by preliminary cecostomy or ileostomy at the time of resection has greatly improved surgery of the colon. The cecostomy sidetracks the intestinal content and improves the general condition of the patient. It allows the inflammatory reaction to subside so that subsequent resection by whichever method is less difficult. Ileostomy with a Pezzer catheter or cecostomy reduces the danger of gas pressure on the anastomosis, minimizing subsequent necrosis and leakage.

Cecostomy is performed by bringing up the cecum and fixing it with sutures extra-peritoneally, to be opened twenty-four to forty-eight hours later with the cautery. A catheter may be inserted and held in place with a purse string suture when drainage is urgently demanded. First the cecum is punctured with a trocar attached to suction. When the sigmoid is used for a colostomy it is necessary to bring out the colon over a rod, the so called loop colostomy. This type is more difficult to close than the above described cecostomy, or tube cecostomy, which often closes spontaneously.

In cases involving the right colon which are not obstructed an ileo-transverse colostomy, followed by later resection of the terminal ileum, cecum, ascending colon and portions of the transverse colon, may be done. This is safer than a one stage and eliminates a cecostomy. The ileum is divided and the distal end closed asep-



tically and dropped back into the abdomen.

Side to side anastomosis is safer than end to end or end to side because there is less chance of interference with the blood supply.

The Mikulicz method consists of bringing out a loop of diseased bowel and excluding it from the peritoneal cavity by sewing the peritoneum, fascia and skin snugly about it. The loop is removed forty-eight hours later with a cautery, leaving a double barreled colostomy. About ten days later this is cut through with a Kocher clamp, making a trough through which the intestinal contents will flow. This is a quick method and safe because it eliminates to a large extent the danger of peritonitis. Its disadvantage lies in the inadequate removal of mesenteric glands, which makes it unsatisfactory in certain conditions.

Improvement has resulted by a modification of the Mikulicz method known as obstructive resection. This removes the diseased bowel and mesentery at the time of operation and, the loops are brought together with the clamps in place and approximated by suturing the anti-mesenteric borders. As the bowel is removed by cautery the method is aseptic. The loops are extra-peritonealized as in the Mikulicz operation and the subsequent treatment the same. Some advise bringing the loops out about two inches above the skin and anticipate the necessity of closing the colostomy, whereas others allow the loops to retract and hope for spontaneous closing. This method has the advantage of a colostomy plus the safety which is lacking in any intra-peritoneal anastomosis. The patients can leave the hospital in three weeks usually, and return after three months for extra-peritoneal closure of the colostomy if necessary. This method may be used any place where the loops can be brought out of the abdomen. In partial obstruction it may be used and a tube can be placed in the proximal loop, above the clamp, with a purse string suture. In acute obstruction however, colostomy must be performed, to be followed later by resection. The obstructive resection is the least difficult and the safest in the hands of the average surgeon and is especially indicated on the left side and in poor risk patients on both sides. The chief obstacle is the long convalescence necessary before closure of the colostomy.

Preoperative treatment consists in cleaning

the tract with castor oil and colon irrigations. Intravenous saline and glucose and blood transfusions to combat dehydration and anemia are necessary. If obstructed, gastric suction with colon irrigation are used preparatory to decompression.

Postoperative treatment consists of saline and glucose, blood transfusion, plus the usual care following any major operative procedure.

The anaesthetic may be spinal, cyclopropane, ether, or a combination of the latter.

Preliminary vaccination is of doubtful value but there is some evidence that the administration of sulphanilamide is beneficial. Improvement in preoperative and postoperative treatment, plus refinement of technique, has reduced the mortality from 40% to 10% in the last twenty years.

### Conclusion:

1. Primary resection has the highest mortality and should never be used on the left side and seldom on the right.
2. Ileotransverse colostomy, followed by resection, is the method of choice on the right side. If primary resection is done it should be accompanied by an ileostomy. Poor risk cases should have an obstructive resection.
3. On the left side the obstructive resection is the safest. Cecostomy, followed by either open or closed resection, is the next safest. However, at the recto-sigmoid junction, cecostomy with subsequent end to end anastomosis is the only available method, as it is impossible to bring the distal segment out of the abdomen.
4. Acutely obstructed cases should all have a cecostomy, but those partially obstructed, on either side, may be handled by the obstructive resection.

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# An Outbreak of Gastro-Enteritis in Middletown in 1938

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Late in the summer of 1938, the author began seeing increasing numbers of cases of gastro-enteritis among the children in and around Middletown; so many, in fact, as to assume the proportions of an epidemic. The characteristics of the disease were: sudden onset of vomiting, with or without diarrhea; moderate fever; mild to definite redness of the throat; and pain in the abdomen. The course of the disease was from three to seven days and ended in complete recovery in each case. What brought the matter to the fore was an outbreak of this same disease in one of the local schools where some forty or more children were out at one time. Curiously enough, a similar epidemic occurred at the Connecticut State Hospital at about that same time affecting patients and employees alike. Dr. Palmieri, the local health officer, investigated food, water and milk, both at the school and in the homes of the children, without finding the cause. Dr. Beauchemin, at the Connecticut State Hospital made a similar investigation, again without success. What finally furnished the clue was the almost constant finding of a moderate or mild redness of the throat. Throat cultures, in each case, showed a non-hemolytic, short-chain, streptococcus, somewhat larger than the usual organism. Among the children this same organism was recovered in the stools in practically all of the cases studied. At the State Hospital, Dr. Beauchemin, found this same organism in the throats of the patients, but was never able to recover it from the stools. Unfortunately no further laboratory work was done on the organism after isolation.

The following cases, reported briefly, show the similarity of signs, symptoms, and course of the disease.

1. Patricia F. Age 6, onset with vomiting, pain in abdomen. Temp. 97 (M), throat mildly red, chest clear, abdomen not tender. Recovery in three days.

2. Richard F. Age 5, vomited once, pain in abdomen. Temp. 102 (R), throat not red, chest showed an occasional rale at right base (not heard the following day), abdomen tympanitic, not tender. Recovery in four days.

3. Betty F. Age 3, vomiting, pain in abdomen, no

diarrhea. Temp. 99.6 (R). Throat red, chest clear, abdomen tympanitic and tender. Recovery in five days.

4. Richard G. Age 2, diarrhea, no vomiting, pain in abdomen. Temp. normal, throat mildly red, chest clear, abdomen tympanitic, not tender. Recovery in four days.

5. John G. Age 9, vomiting, sore throat, Temp. 101 (M). Throat red, chest clear, abdomen tympanitic and tender. Recovery in six days.

6. George H. Age 2, vomiting, sudden onset, pain in abdomen, no diarrhea, no fever. Throat mildly red, abdomen tympanitic not tender. Recovery in forty-eight hours.

7. Sumner H. Age 4, pain in abdomen, no vomiting, no fever. Throat red, chest clear, abdomen very tympanitic and tender. Recovery in six days.

8. Patricia A. Age 2, sudden onset of vomiting, pain in abdomen. Temp. 101 (R). Throat red, chest clear, abdomen tympanitic not tender. Recovery in four days.

9. Carol B. Age six, sudden onset, vomiting, no diarrhea, head ache, pain in abdomen. Temp. 101 (M). Throat red, chest clear, abdomen tympanitic. Recovery in three days.

10. Patricia B. Age 7, vomiting, pain in abdomen, no diarrhea. Temp. 100 (M). Throat red, chest clear, abdomen tympanitic not tender. Recovery in seven days.

11. David B. Age 8, vomiting, pain in head and abdomen, no diarrhea. Temp. 99 (M). Throat red, chest clear, abdomen tympanitic and tender. Recovery in four days.

12. Zencia B. (Sister of David B.). Age 5, pain in abdomen, no vomiting, no diarrhea, no fever. Throat not red, chest clear, abdomen tympanitic, not tender, recovery in 48 hours.

13. Eileen C. Age 5, vomiting, no diarrhea. No fever, pain in abdomen, throat not red, chest clear. Abdomen tympanitic not tender. Recovery in four days.

14. Marjory C. Age 3, vomiting, fever, pain in abdomen. Temp. 101 (R). Throat red, chest clear, abdomen tympanitic and tender. Recovery in seven days.

15. Eleanor D. Age 2, vomiting and diarrhea, fever. Temp. 102 (R). Throat red, chest clear, abdomen tympanitic and tender. Recovery in five days.

16. Gilbert J. Age 3, vomiting and diarrhea, fever. Temp. 101 (R). Throat red, chest clear, abdomen tympanitic not tender. Recovery in five days.

17. Richard K. Age 7, vomiting, sore throat. Temp. 100 (M). Throat red, chest clear, abdomen tympanitic not tender. Recovery in four days.

18. Fred K. Age 6, vomiting, fever, pain in abdomen. Temp. 101 (M). Throat red, chest clear, abdomen tympanitic and tender. Recovery in five days.

(Concluded on Page 646)



## The Right to Practice Is in Jeopardy

### Is it Advisable to Become Amicus Curiae?

To the Editor:

We have had a legal opinion in connection with the Waterbury case handed us which is of far more importance to the medical profession as a whole than pertains to our immediate problem. Therefore, we feel that certain paragraphs, denuded of the long legal argument and translated into advice, should be presented through the columns of the Journal. It would seem advisable for the Council and component county medical societies to consider securing legal protection for our interests wholly aside from the question of contraception.

Respectfully submitted,

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 Dr. George Gildersleeve, Norwich  
 Dr. Francis Sutherland, Torrington  
 Dr. Dorothea Scoville, New London  
 Dr. William Darrach, Greenwich

Dr. Roy Ferguson, Rockville  
 Dr. Ed. Ottenheimer, Willimantic  
 Dr. John H. Foster, Waterbury  
 Dr. A.N. Creadick, New Haven,  
 Chairman

*Medical Advisory Committee  
 Connecticut Birth Control League*

Two reputable doctors and a registered nurse, in Waterbury, have been arrested, charged with crime, and threatened with fines or imprisonment or both. The accused were arraigned in court and released in the custody of their counsel. Clinical records, materials and appliances were impounded. Three judges who separately heard the preliminaries arrived at different conclusions. The issues will be appealed to a higher Court.

If the doctors were convicted, the outcome would be disastrous enough since it would outlaw scientifically approved treatments in a particular field of medical practice. But beyond that, the precedent and legal principle established by the conviction would have the gravest significance to every respectable physician in Connecticut. The same principle might be extended into *every* field of practice, to impose intolerable restraints upon the doctor's freedom to exercise his necessary discretion in advising his patients. If the clinical records were publicly exposed, that would undermine the confidential privacy which should surround the doctor-patient relationship. If the impounded materials and appliances were finally confiscated, that might mean that corresponding private equipment of any doctor might be seized

as evidence of crime, and his office raided for the purpose.

The Waterbury doctors and nurse have been charged, as accessories, under a Connecticut statute enacted in 1879 (Section 6246) which provides:

"Any person who shall *use* any drug, medicinal article or instrument for the *purpose* of preventing conception shall be fined not less than fifty dollars or imprisoned not less than sixty days nor more than one year or be both fined and imprisoned."

The accused doctors, at the Chase Memorial Dispensary of the Waterbury Hospital, gave bona fide advice to married women upon the use of contraceptives for the safeguarding of health or life. The nurse carried out the doctors' orders.

Because the statute penalizes the "*use*" of contraceptives, the patients using them would be primarily liable. Nevertheless, if the statute validly applies to conscientious doctors, they could not escape liability simply because they had not *used* the materials; they would be guilty as accessories if they advised and therefore contributed to the alleged criminal act. Doctors so advising could not elude criminal guilt unless the law be so interpreted as to exonerate phy-

sicians who recommend contraceptives in the sincere belief that their use is medically indicated.

The Waterbury doctors and nurse sometimes served a "Birth Control" clinic of the Chase Memorial Dispensary. There medical advice was given gratuitously, or largely so, to women who could not pay for private consultation. So, to some extent, the criminal charges attack the Birth Control movement.

On the other hand, the charges against the doctors have implications that extend far beyond the territory of charitable clinics, and invade the innermost regions of the personal practice of every Connecticut doctor who ventures to counsel married women upon problems of sex and childbearing. Innumerable doctors have believed it their inescapable duty, in routine private practice, to recommend contraceptives. Those doctors must face criminal responsibility unless they are exempted by an appropriate interpretation of the statute. The doctors immediate problem is wholly separated from the generalities of the Birth Control movement and its social and economic objectives. The problem focuses upon the single question whether, under threat of criminal prosecution, a doctor must refuse to recommend contraceptives, however indispensable he may consider them to be, in his scrupulous opinion, for the best scientific treatment of his patients.

A wider issue than that of Birth Control as discussed by Dr. Foster (Jour. Ct. State Med. Soc. III, 8:399) is involved. The fundamental issue raised by the arrest of the doctors is this: Has the legislature the power by statute to prohibit the practice of medicine by the physician according to the dictates of medical science and his best judgment? The contention of the state in the Waterbury case is that the legislature has such power even though the statute upon which the case is founded appears among the laws designed to prevent offenses against chastity and does not have as its express purpose the limiting of the right to practice medicine. If, therefore, the state prevails, Connecticut, by the decision of its highest court, will be on record as sanctioning the legislative control of the practice of medicine.

Let us consider the above statement in the light of the legislation on which it would be founded:

The statute in question is a flat prohibition of the use of contraceptives *by any one* for the purpose of preventing conception. The doctors are drawn within the orbit of its force by virtue of another statute which makes any person guilty of a crime who aids, counsels or abets another in the commission thereof. From this it follows that in cases of medical necessity, no matter how serious in the opinion of the doctor may be the consequences of his patient's becoming pregnant, there is only one legal course open to him. That course is sterilization; under the provisions of Section 2684 a doctor may perform a vasectomy or oophorectomy if the operation "shall be a medical necessity." As few cases arise that would in the judgment of a physician justify such a course the only other prescription open to him is the advice of total abstinence.

That the issues raised by the Waterbury case strike a vital blow at the liberty of the doctor to practice as he sees fit is more strikingly illustrated if we consider the circumstances surrounding the arrests. The facts are that the statute in question has been on the books for 60 years. During that time the distribution of contraceptive devices has proceeded unmolested through dozens of retail channels. *Yet not until a group of reputable doctors, assisted by a registered nurse, commenced the operation of a birth control clinic within the walls of a reputable hospital did the state authorities see fit to enforce the statute.*

The significance to the profession of the case involving the seizure of the materials and records of the clinic remains to be considered.

That deed raises the correlative issue; namely, whether the state may confiscate doctors' private records under a "search and seizure" statute designed to permit the seizure of articles calculated to foster counterfeiting, betting, lotteries and the like. Here again, if the state's contention is upheld a doctor's records will not be safe from seizure, no matter how confidential and intimate the nature of them may be if they can be used to convict him of a statutory crime.

Let us suppose as we have already suggested, that the legislature at some future time sees fit to prohibit the use of a certain drug or certain medical procedure. Under the state's theory of the Waterbury case the doctors' records would



# State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

## The State Services for Crippled Children: A Fifteen Months' Summary

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In this State-wide crippled children program the active participation of physicians and surgeons, professional and lay organizations, and State agencies has been enlisted. Through the advisory committees, medical, dental, nursing, educational, social and crippled children groups are in constant touch with the activities of the Division of Crippled Children, and help formulate and direct them.

During the fifteen-month period from February 1938, when the first crippled children clinic was held, to May 1, 1939, medical surgical and related services have been given to 663 persons coming from almost every area of the State (Map I). Six hundred fifty-five new patients have been seen at 81 clinics; an average of 8 per clinic, or 44 each month. Eight patients have been seen at the consultants' offices only. A total number of 1724 clinic visits have been made; an average of 21 per clinic, or 115 each month (Table I). At this time, 485 cases are on the active list; 178 cases have been closed. The reasons for closing these cases are given in Table II. From this table, it can be observed that reduplication of medical services is avoided. Patients who have conditions not treatable under the State plan are referred to appropriate agencies; they are not lost sight of until their adequate care is ensured.

Table III gives the diagnostic classification of the patients. Slight changes from that of a previous classification<sup>1</sup> have been made, chiefly in the grouping of cerebral palsy, heart disease and epiphyseal disturbances. A broader view of the classification may be had by a regrouping of the crippling conditions in percentages of the total number as in Table IV.

In a previous issue of the Journal of the Connecticut State Medical Society<sup>2</sup>, there are charts showing the number of admissions and hospital days per month from March 1938 to October 1938. Table V gives the total number of admissions and the number of hospital days for each hospital during the fifteen-month period.

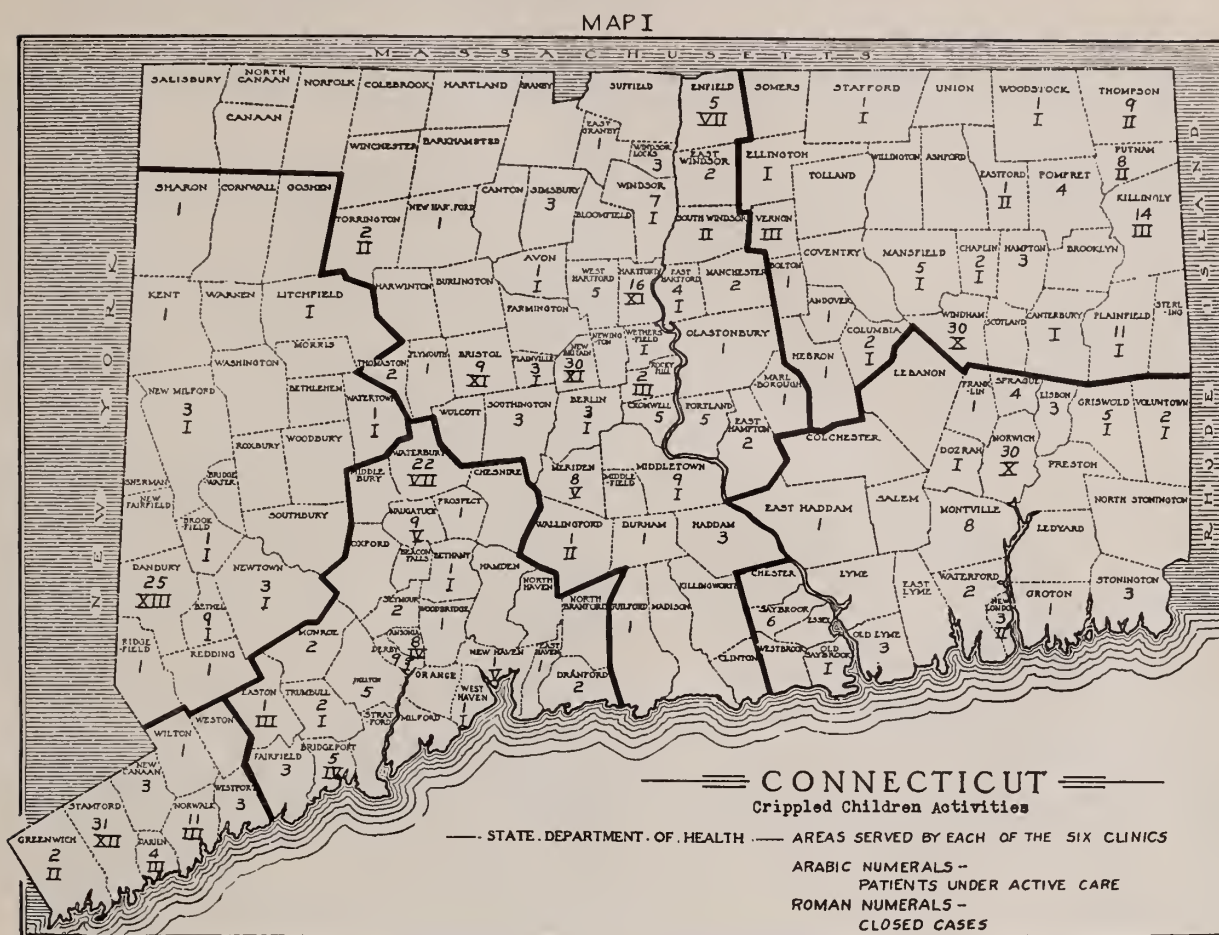
Occasionally convalescent care is provided in convalescent or foster homes. Table VI indicates the number of patients who have had such care, and also shows the total days in these homes.

Map II shows the location of the clinics, hospitals used for hospitalization and physical therapy centers. It will be noted that physical therapy treatments are given by two State technicians in 5 centers representing areas where such treatments are not available locally. There are 10 physical therapy centers under local auspices open to State crippled children patients. The number of patients receiving physical therapy treatments and the number of treatments rendered are shown in Table VII.

Speech training has been recently instituted for patients with cerebral palsy and repaired harelip and cleft palate who have speech defects. Children living in the northern part of Connecticut receive instruction at the Newington Home for Crippled Children. A teacher is to be obtained for patients residing in the southern section of the State.

Consultants to the Division of Crippled Children comprise physicians and surgeons who are certified by the boards of the respective specialties. Consultation service is rendered on orthopedic and non-orthopedic crippling conditions (Table VIII). Fifty-five patients

\*Chief, Division of Crippled Children, Bureau of Child Hygiene.



**TABLE I**  
**NUMBER OF NEW PATIENTS AND CLINIC VISITS**

Location of Clinic		Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	Totals
Newington	(new)	..	22	47	32	17	23	13	10	5	7	15	3	4	7	8	220
	(old)	..	0	1	5	9	10	18	23	20	16	21	21	20	22	26	212
	(total)	..	29	48	37	26	33	31	33	25	23	36	24	24	29	34	432
Willimantic	(n)	17	11	12	11	10	6	8	9	8	8	5	3	3	3	4	118
	(o)	0	8	12	11	14	19	28	17	27	29	21	19	11	17	25	258
	(t)	17	19	24	22	24	25	36	26	35	37	26	22	14	20	29	376
Derby	(n)	..	..	..	..	..	..	11	2	6	6	5	5	6	6	4	51
	(o)	..	..	..	..	..	..	4*	3	9	5	9	7	10	13	11	71
	(t)	..	..	..	..	..	..	15	5	15	11	14	12	16	19	15	122
Danbury	(n)	13	11	12	1	1	7	6	1	6	..	4	5	4	6	7	84
	(o)	0	1	4	5	2	8	14	18	18	..	15	14	9	9	14	131
	(t)	13	12	16	6	3	15	20	19	24	..	19	19	13	15	21	215
Norwich	(n)	11	15	9	6	4	9	5	6	4	7	4	2	6	6	3	97
	(o)	0	1	7	6	12	20	15	13	19	22	13	19	23	27	12	209
	(t)	11	16	16	12	16	29	20	19	23	29	17	21	29	33	15	306
Stamford	(n)	..	14	9	14	8	4	5	3	7	1	2	2	6	6	4	85
	(o)	..	0	3	7	13	21	11	14	15	12	16	23	17	17	19	188
	(t)	..	14	12	21	21	25	16	17	22	13	18	25	23	23	23	273
TOTALS	(n)	41	80	89	64	40	49	48	31	36	29	35	20	29	34	30	655
	(o)	0	10	27	34	50	78	90	88	108	84	95	103	90	105	107	1069
	(t)	41	90	116	98	90	127	138	119	144	113	130	123	119	139	137	1724

\* Patients transferred from other clinics.



TABLE II  
REASONS FOR CLOSING CASES

Treated elsewhere.....	55
Condition not treatable under State plan.....	31
Severe mental handicap.....	27
No further treatment needed.....	23
No disease.....	17
Moved out of State.....	8
Over age.....	4
Prognosis hopeless.....	4
Financially ineligible.....	4
Treatment refused.....	4
Death.....	1

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178

TABLE III  
DIAGNOSTIC CLASSIFICATION OF PATIENTS\*

Acromegaly (gigantism).....	1
Adhesion, congenital, glossopharyngeal.....	1
Amputation of extremity, congenital.....	2
Amputation of extremity, traumatic.....	7
Arthritis, cause not determined.....	4
Arthritis, rheumatoid.....	7
Arthritis, septic.....	1
Arthritis, Strumpell-Marie.....	1
Arthritis, tuberculous (proven or suspected).....	4
Arthrogryposis multiplex congenita.....	2
Cerebral palsy:	
Athetosis.....	2
Hemiplegia.....	31
Monoplegia.....	3
Paraplegia.....	10
Quadriplegia.....	8
Chondrodystrophy.....	1
Chorea.....	1
Cleft palate (with or without cleft lip).....	35
Clubfoot.....	15
Contracture of, cause not determined,	
hamstrings, 2; gastrocnemii, 1; plantar ligaments, 4	7
Contracture, due to burn.....	10
Contracture, due to infection.....	2
Contracture, due to trauma.....	7
Contracture, Volkmann's.....	1
Coxa vara.....	4
Cyst of bone.....	2
Deformity, congenital, of arm.....	1
Deformity, congenital, of fingers.....	4
Deformity, congenital, of foot.....	1
Deformity, congenital, of hand(s).....	5
Deformity, congenital, of toes.....	2
Deformities, congenital, multiple.....	8
Deformity of nose.....	4
Dislocation, congenital, of hip(s).....	16
Dislocation of elbow, reduced.....	1
Dislocation of hips, due to infection.....	2
Epilepsy.....	2
Facial paralysis (poliomyelitis, 2; mastoiditis, 1) ..	3

Flatfoot (and related postural disturbances of feet)...	54
Foreign body in hand.....	1
Fracture, of finger.....	1
Fracture, malunited.....	4
Ganglion, of wrist.....	2
Genu valgum (knock-knee).....	9
Genu varum (bowleg).....	8
Goiter, diffuse with hyperthyroidism.....	1
Harelip.....	5
Heart disease, congenital.....	8
Heart disease, rheumatic.....	10
Hemiatrophy.....	2
Hemophilia (?).....	1
Hip disease, cause not determined.....	2
Hydrocephalus.....	4
Incontinence of urine.....	2
Injury to head.....	2
Kyphosis.....	5
Mental deficiency, developmental cranial anomalies..	16
Microcephaly.....	1
Monoplegia, flaccid, cause not determined.....	2
Multiple sclerosis.....	1
Muscular dystrophy (and allied disturbances).....	9
Naevus.....	3
Obstetrical paralysis.....	27
Osteochondritis dissecans.....	6
Osteochondroma.....	4
Osteochondrosis of ilium.....	1
Osteochondrosis of femur, capital epiphysis of (Legg-	
Perthes).....	7
Osteochondrosis of navicular (Koehler's disease)....	1
Osteochondrosis of vertebrae.....	4
Osteogenesis imperfecta.....	1
Osteomyelitis, chronic.....	11
Parkinson's disease.....	1
Paraparesis, flaccid.....	1
Periostitis.....	1
Poliomyelitis, residual paralysis.....	87
Rickets, healed.....	6
Scoliosis.....	38
Schuller-Christian's disease.....	1
Semilunar cartilage, instability of.....	1
Shortening, congenital, of extremity.....	2
Speech defect.....	7
Spina bifida.....	10
Spondylolisthesis.....	1
Sprain, ankle.....	1
Sprain, lumbosacral.....	1
Thrombosis of arteries.....	1
Torticollis (wryneck).....	20
Tumor of spinal cord.....	1
Winged scapula.....	5
Diagnosis deferred.....	11
No disease.....	18
Miscellaneous conditions not eligible for treatment	
under the State program.....	16
	—
	663

\* No patient is listed for more than one diagnosis, only the principal diagnosis being used if more than one clinical condition is presented in the same case.

TABLE IV  
REGROUPING OF CRIPPLING CONDITIONS IN PERCENTAGES

Congenital.....	25%
Scoliosis, foot and other disturbances.....	16%
Poliomyelitis.....	15%
Cerebral palsy.....	9%
Obstetrical paralysis.....	5%
Accidents.....	5%
Miscellaneous.....	25%
	100%

TABLE VI  
CONVALESCENT AND FOSTER HOME PATIENTS AND TOTAL NUMBER OF DAYS

	Number of Patients	Number of Days
Convalescent homes.....	3	480
Foster homes.....	2	146
	5	626

TABLE V  
HOSPITAL ADMISSIONS AND TOTAL NUMBER OF DAYS

	Number of Admissions	No. of Hospital Days
William W. Backus Hospital, Norwich.....	15	239
Bridgeport Hospital.....	17	434
Danbury Hospital.....	2	103
Hartford Hospital.....	20	517
Memorial Hospital, New York City.....	2	169
New Haven Hospital.....	50	1212
Newington Home for Crippled Children.....	20	2167
Roosevelt Hospital, New York City.....	1	20
St. Francis Hospital, Hartford.....	5	321
St. Vincent's Hospital, Bridgeport.....	21	543
Windham Community Memorial Hospital, Willimantic.....	35	1009
	188*	6734

\* The total number of admissions includes 26 readmissions.

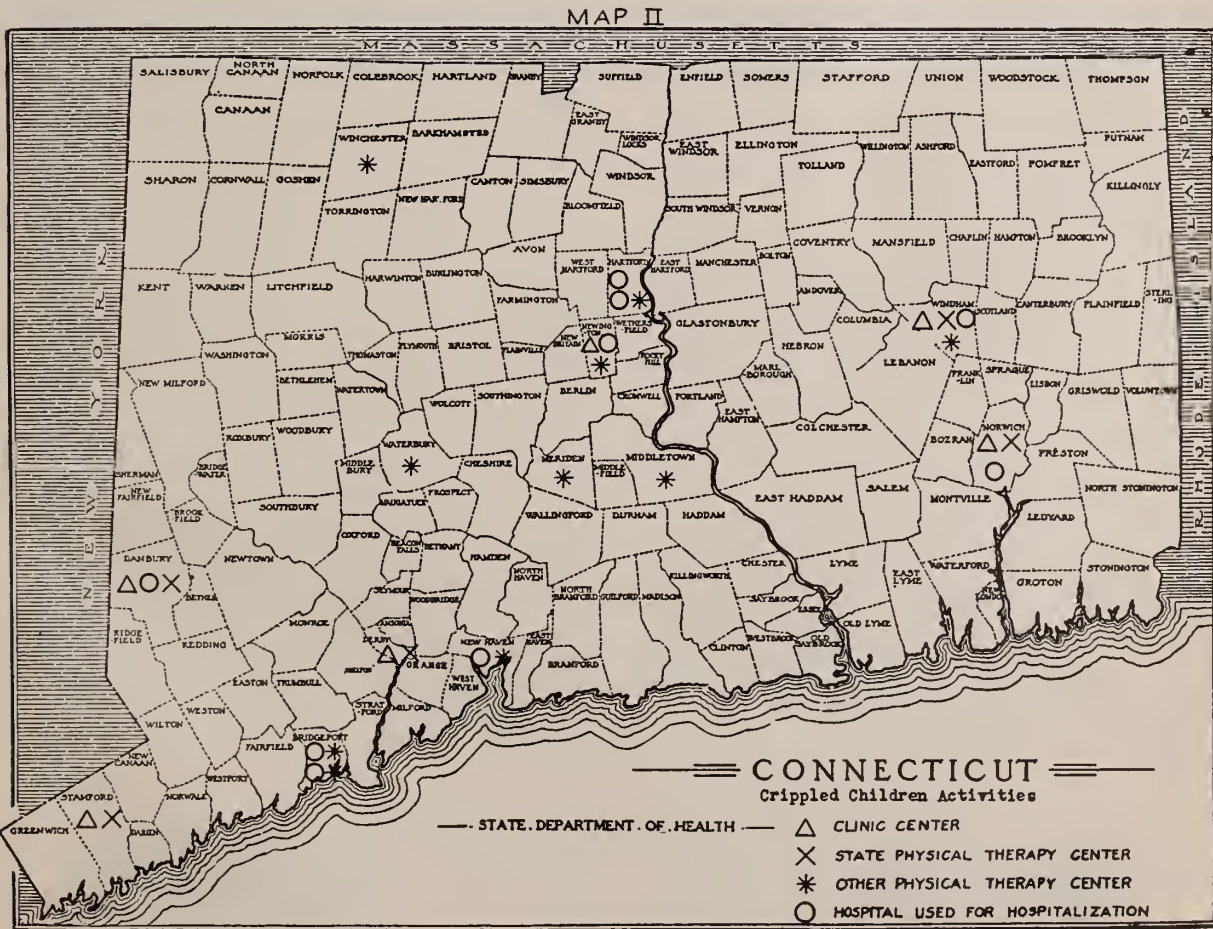




TABLE VII  
PHYSICAL THERAPY PATIENTS AND TOTAL  
NUMBER OF TREATMENTS

	Number of Patients	Number of Treatments
Under care of State technicians..	120	2236
Under care of other technicians..	27	1317
	147	3553

TABLE VIII  
CONSULTATION SERVICES

Type	Number
Surgery:	
General.....	48
Neurosurgery.....	13
Ophthalmology.....	1
Otolaryngology.....	17
Pediatrics.....	23
Psychiatry and psychometric examinations.....	15
Neurology.....	28
Urology.....	4
	149

were hospitalized for study and treatment by the consultants; 11 were readmitted.

The total number of nursing visits made to crippled children from April 1, 1938, to April 1, 1939, whether cared for by the Division of Crippled Children or by other agencies, numbered approximately 1830.

Each patient has been interviewed by the medical social worker at least once. Many patients have required several home and clinic interviews. The above number is not indicative of the extensive services given by more than 200 social, educational, nursing and medical agencies.

#### Summary

1. A brief statistical summary of the State crippled children program is outlined.
2. Reduplication of services is avoided.
3. Existing facilities are used wherever available.
4. The Division of Crippled Children is acting as a clearing house for patients who are not treatable under the State plan; they are transferred elsewhere for the necessary care.

5. The State crippled children services include not only medical and surgical care, but also related services such as nursing and social welfare.

6. The participation of over 200 agencies illustrates the State-wide interest in the care of crippled children.

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- (1) Fuldner, R. V.: Conn. Health Bulletin 52: 263, Oct. 1938.
- (2) Fuldner, R.V.: J. Conn. State Med. Soc. 2: 618, Dec. 1938.



#### ENGLAND COMPLETING ARRANGEMENTS FOR WARTIME MEDICAL SERVICE

"The central and local emergency committees of the British Medical Association will be responsible during the war for the supply of medical personnel for the fighting forces and for the civilian population," the regular London, England correspondent of *The Journal of the American Medical Association* reports in the Oct. 7 issue. "First aid posts have been set up with the intention of protecting casualty hospitals from a rush of minor and ambulant cases and of providing early treatment in districts where the hospital is some distance away. The function of the first aid post is (1) to treat and send to their homes those who are slightly injured and those suffering from nervous shock; (2) to arrest hemorrhage, relieve pain and so prepare persons who may be found to need institutional treatment that they can be transferred to the casualty hospital with the least possible harm.

"The Ministry of Health Emergency Service has recommended that as far as possible all persons with open wounds shall receive a prophylactic dose of tetanus antitoxin, which is being stored at more than fifty centers throughout England and Wales so as to be quickly available for use both at the first aid posts and at hospitals. Supplies of gas gangrene antitoxin are being held in the big centers throughout the country and will be available for surgeons whenever required."

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**MANUSCRIPTS.**— Manuscripts should be type-written, double-spaced, on white paper  $8\frac{1}{2} \times 11$  inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

**ILLUSTRATIONS** — Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

**NEWS.**— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

**ADVERTISEMENTS.**— All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

**SUBSCRIPTIONS.**— Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

**REPRINTS.**— Reprints of papers and obituaries may be obtained from the Editor at cost.

## • Editorials •

### POLIOMYELITIS VIRUS IN SEWAGE

The five-minute talk given by Dr. James D. Trask at the recent meeting of the Clinical Congress on the subject: "Modes of Transmission in Poliomyelitis" is published elsewhere in this issue of the Journal (page 595). Although the brief statement was thoroughly overlaid with precautionary reservations, the audience recognized at once the importance of a communication which was in effect the first public announcement of a discovery made by Dr. Trask, Dr. John R. Paul, and their associates as a result of their investigations conducted at the Yale University School of Medicine with the aid of grants from the President's Birthday Ball Commission for Infantile Paralysis Research.

After pointing out that the nose may not be the only portal of entry of the virus of poliomyelitis, Dr. Trask reported that the experimental disease in susceptible monkeys may follow almost any method of administration of the virus: intranasal instillation, intracutaneous, subcutaneous, intraperitoneal, intraneural inoculation; and by way of the gastro-intestinal tract when the virus is added to the food. All of these experimentally determined facts must now be taken into more definite consideration by physicians, sanitary engineers and epidemiologists. The possibility of gastro-intestinal transmission may assume particular importance.

Confirming earlier work of Kling and others, Trask, Vignec, and Paul<sup>1</sup> in 1938, reported the finding of poliomyelitis virus in human stools. The virus may remain active in refrigerated specimens of stools for as long as two and a half months. These observations naturally suggested a search for the virus in sewage. Tests made by these workers during the past year proved that the virus existed in the sewage in Charleston<sup>2</sup> and in Detroit. The virus was present in large amounts and remained active in sewage for twelve days. It is to be emphasized that the samples were taken from sewers close to hospitals in which there were patients with poliomyelitis.



This discovery has widespread implications and raises many questions as to the possible importance of sewage as a means of transmission of poliomyelitis through contamination of drinking water, pools, streams, and bathing beaches. The questions cannot be answered without much more research. At present it is not known whether the virus in sewage is capable of infecting human beings. Other questions, unanswerable at the moment are: how far can the virus travel in sewers?, how much can accumulate there?, how long can it survive in sewage?, can the virus pass through sewage disposal plants?

Every effort should be made to find out whether the presence of the virus of infantile paralysis in sewage is of practical importance or not. If it is, a new light will have been thrown on an avenue of transmission of the disease; new methods of treatment of sewage may have to be devised, and new measures of control instituted.

S. B.-J.

1. Trask, J. D., Vignec, A. J., and Paul, J. R., *J.A.M.A.*, 1938, **111**, 6.
2. Paul, J. R., Trask, J. D., and Culotta, C. S., *Science*, 1939, **90**, 258.

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### THE SUPREME COURT HANDS IT BACK TO MR. ARNOLD

Somewhat to our surprise the Supreme Court on October 23 refused to pass on the suit charging the American Medical Association, the Medical Society of the District of Columbia, as well as several individuals, with conspiracy to violate the Sherman Anti-trust Law. By this refusal Assistant Attorney General Arnold's suit reverts to the United States Court of Appeals for the District of Columbia. The decision is not only surprising but is eminently satisfying. We had been led to expect different treatment at the hands of the present Supreme Court. Honorable Frank J. Hogan, President of the American Bar Association, recently expressed regret at the manner in which our highest judicial body has been willing to depart from established principles, liquidating them "so effectively that as the Court said they 'cannot survive.'"

The suit in question may yet reach the Supreme Court after action has been taken by the

Court of Appeals. By this procedure time honored methods will not be discarded. The United States Justice Department, according to the Associated Press, believes that a decision by the Supreme Court would "affect the conditions of medical practice throughout the United States." The Editor of the Journal of the American Medical Association is quite certain that such a decision "will not determine in any degree the truth or falsity of the charges against the American Medical Association and others." Thus our faith in the Supreme Court is warranted; thus we unswervingly retain our belief in the profession's right as a whole to carry on as its conscience dictates.

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### DOCTORS AND WAR

Physicians can look at war with fine abstraction, they are essentially men of peace, only rarely do they become warriors like Warren and Wood. The man of medicine has a high sense of moral values deeply rooted in an inherent charity and simple integrity. By training and temperament he is held aloof from the intrigues and aggressive plots of statesmen, he conquers empires by saving lives, not wasting them, and his heart is slow to respond to the maudlin patriotism that impells the mass. Although he is the first to go when it starts and the last to come back when it is over and he patches up friend and foe with fine impartiality, he is reluctant to take his scalpel and his skill and sally forth to war for he knows the futile tragedy of it. Medicine is always on the battle front of life waging war on the enemies of mankind but not on man, its Creed is Peace and Good Will.

C. B.

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### THE RADIO BALLYHOO

Tooth pastes and powders, cathartics, antacids, cosmetics and patent medicines continue to interrupt our radio musical programs and irritate us as we are listening to the latest transradio news. How long will the American public be so gullible? Just as long as there is money to be made by this kind of propaganda and the radio public will put up with the jarring jargon of these jerry-builders.

Radio advertising was given considerable prominence on the program of the conference of

the Association of Food and Drug Officials of the United States recently convened at Hartford. It was advocated that radio advertising copy be filed and subjected to the close scrutiny of food and drug officials on the same basis as newspaper and magazine advertising. Why not? The detrimental effect of radio in broadcasting misleading information is in direct violation of the Food, Drug and Cosmetic Act. As Dr. George R. Cogwill of Yale University said, the general impression given in radio advertising is usually erroneous and if the claims of radio advertisements were included in the written advertisements or on labels, they would be immediately considered a violation of laws.

Our neighbor, Canada, does not allow its radio audience to be duped and bored with all this ballyhoo. Are we in the United States of any less intelligence? It would be a boon to our nerves and a solace to the various parts of our anatomy to which the appeals are directed if the food and drug administrators would adopt a policy similar to that used by the Council on Pharmacy and Chemistry of the American Medical Association whereby data on food and drug products are collected and reported to the public. Surely all claims amenable to scientific tests, chemical or biological or both, should be supported by the appropriate tests.



### THE CHURCH IN CONFUSION

It is not often that the social behavior of physicians may be favorably compared with the clergy, but there does come a time. A. Warden, M.D., which sounds like a pseudonym, writing to the Editor of the Connecticut Churchman comments; "Having been a delegate to several recent Diocesan Conventions it is natural that I should have received some general impressions of these gatherings. One of the strongest of these is the amount of confusion which exists in the corridor and in the back of the Convention hall itself during the progress of the sessions. There will inevitably be some coming and going by individuals, for various good and sufficient reasons, there may well be cause for a whispered comment or question between neighbors on some point of the discussion currently under way, but there seems to me to be no reasonable justification for the prolonged sotto voce conver-

sations so prevalent in the back rows in the hall. The sum total of the noise produced is not only distracting but may even drown the voice of a speaker who is not speaking loudly.

Since the recent convention I have been to the annual meeting of the State Medical Society. There was the same coming and going as at the Convention, but there was no talking or whispering in the back rows. I have never heard it said that the manners of the medical profession were superior to those of the clergy, but if these two assemblages are to be taken as true indicators there can be no comparison which will not be in favor of the doctors."

Thank you, Doctor Warden, we want quiet in the back rows.

C. B.



### ROCK THE BOAT AT ANY TIME

The results obtained by the editorial staff of the Medical Annals of the District of Columbia from a questionnaire on what its readers wished published is about as illuminating as the modern "black out." Almost everything conceivable in medical journalism was called for. Some wanted reports of clinical pathologic conferences in full size print as they do in Boston, others wished to have such conference reports omitted. Perhaps the most striking demands were for glimpses from a larger field of material, more governmental health news, more personal and social items, recent advances in the specialties, statistics of maternal and fetal mortality and of the effects of various anesthetics and sedatives administered during labor, reports of new instruments, new drugs, experimental work on vitamins, blood and endocrines, more jokes, more illustrations, more symposia on various subjects.

It all goes to show that you can't be superhuman.

One Washingtonian replied, "A fine job — don't rock the boat."



### THE JOURNAL OF CRIMINAL PSYCHOLOGY

A very handsomely bound copy of Volume 1, Number 1, Journal of Criminal Psychology, has been received by your Editor. It appears as a quarterly publication from the Woodbourne In-



stitution for Defective Delinquents, New York State Department of Correction and is a project of the Institution's class of journalism.

In this first issue appear an article on "Experiment in Silent Reading," one on "Delinquent as a Type and Personality" and another on the "Psychiatric Data Punch Card."

There are twenty-two pages of Abstracts from Current Literature and five pages of Book Reviews. Our congratulations to the Editor, Doctor V. C. Branham, for this excellent product.



### **COURSE IN OBSTETRICS AND GYNECOLOGY AT YALE TO BE CONTINUED THIS YEAR**

The Department of Obstetrics and Gynecology of Yale University announces a series of monthly conferences to be held at the New Haven Hospital during the Fall and Winter months. At these meetings emphasis will be placed on the clinical aspects of Obstetrics and Gynecology. Members of the Connecticut State Medical Society who desire to receive notices stating the date and time of these meetings may do so by writing to the Department of Obstetrics and Gynecology, Yale University School of Medicine, New Haven, Connecticut.



### **A SANITARY WATER DISPENSER**

A doctor of medicine and local health officer in one of our Connecticut towns where a large construction job was employing several hundred men, noticed that the men were being served drinking water from open pails using a common dipper. Several of the men had developed trench mouth disease. He asked the contractor to stop the practice and in turn was asked to suggest a method as there was nothing satisfactory on the market. The health officer then purchased from a hardware store several pails, faucets, covers and containers of collapsible paper drinking cups and directed a tinsmith to assemble them. The result was a water pail easily carried so that the laborer can pull out a cup, draw water from a faucet and, when his thirst is satisfied, he can push the cup through an opening into a compartment under the pail which in turn can be easily removed for disposing of the used cups. Several of these sanitary water dispensers were put to work on the jobs and

proved very satisfactory to both the contractor and the laborers.

In order to have this pail manufactured and placed on the market, a search in the patent office was made and a patent applied for. This sanitary water dispenser will soon be placed on the market so that each contractor will have no excuse for not providing sanitary drinking water to his employees, the same as is now required for factory and other inside employees.



### **SQUIBB OPENS NEW VIRUS LABORATORY**

Establishment of a new laboratory for the study of filterable virus diseases, in the treatment and prevention of which science is believed to be at the threshold of an important advance, is announced by the Squibb Biological Laboratories.

Dr. Raymond C. Parker biologist of the Rockefeller Institute for Medical Research, and for many years an associate of Dr. Alexis Carrel, has been appointed to head the laboratory, which will operate as a unit of the Biological Division of E. R. Squibb and Sons at New Brunswick, N. J. The new building is a continuation of a program of expansion which began in the Fall of 1938 with the dedication to pure science of the \$750,000 laboratory of the Squibb Institute for Medical Research.

The new virus laboratory is housed in a specially constructed building, and is equipped for work with chick embryos and tissue culture, two of the techniques for work in this field. The actual working quarters consist of a large general laboratory equipped with every facility for chemical and histological work, a general preparation room for washing, drying, packing, and storing the various materials that are used, two special culture and operating rooms provided with filtered ventilation, a spacious incubator room, an animal preparation room, a bleeding room, and ample animal quarters.

The arrangement of the rooms is such that the air of the culture suite proper is protected at all times from the air of the general laboratory and office quarters on the one side, and of the animal room on the other. It is also possible for visitors to observe every step of the work in progress without entering any of the various rooms of the culture suite.

# From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street

New Haven

## Special Meeting of the House of Delegates

The House of Delegates held a special meeting in New Haven on September 19 during the Clinical Congress for the purpose of discussing and acting upon the contract for the full time Executive Secretary commencing January 1, 1940, and adopting the Society's budget for the calendar year 1940.

The matter of the Secretary's contract was subject to considerable debate, confused a little by the fact that there were many alternate delegates seated in the House who had not received the agenda for the meeting. Finally the proposal was put to vote and carried with 35 ayes and 9 nays. The budget for 1940 as proposed by the Society's Budget Committee based upon an assessment of \$15.00 per member as approved by each County Association in April and voted by the House of Delegates at its annual meeting in May, was accepted without discussion.

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## Special Meeting of the Council

At the request of the Secretary the Chairman called a special meeting of the Council to review the discussion and vote of the House of Delegates at its September 19th meeting and the Council met in Hartford on September 27. The Council carefully considered what transpired at the meeting of the House and unanimously decided that the vote of the House should stand and that the Society should proceed with the employment of a full time Secretary under the provisions of the contract that had been submitted to the meeting on September 19.

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## State-Wide Meetings for the Discussion of the Treatment of Pneumonia

The Council has approved a cooperative project entered into by the State Society, the State Department of Health and the various local Medical Societies in the State to arrange a series of programs dealing with the modern treatment of pneumonia. During the coming winter a regular meeting of many of the local

Societies will be devoted to the discussion of the treatment of pneumonia and all physicians in the State, whether they are members of the Society or not, will be invited to attend. This Society is pleased to participate in this project that should prove of great value.

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## Governor's Commission to Study Physical and Mental Infirmities

Judge Kenneth Wynne, who had been named Chairman of the Commission to study physical and mental infirmities among the citizens of the State, found it necessary to resign because of press of his judicial duties and Governor Baldwin has appointed Ira V. Hiscock, Professor of Public Health at Yale University, to succeed Judge Wynne as a member of the Commission. The Commission now consists of Doctor William H. Coon of Easton, Doctor Wilmar M. Allen of Hartford, Senator Joseph Downes of Norwich, Professor Hiscock of New Haven and the Secretary of the Connecticut State Medical Society, Chairman.

There has been some unavoidable delay in the organization and procedure of this Commission due largely to the resignations of Mr. Markham, attorney of Hartford, and of Judge Wynne. In spite of this handicap the study of the Norwich State Hospital for the Insane has progressed and conferences with the Governor have been held for the discussion of the scope and policies of the Commissions' activities. With the Commission now organized with its complete personnel it should go on with the important task assigned to it without interruption. The report and recommendations of the Commission must be submitted to the 1941 General Assembly.

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## Addresses to Lay Audiences

Continuing the policy established last year this office is arranging for members of the Society to appear before women's clubs, service clubs and church organizations to present discussions of timely medical topics, particularly



the subject of government medicine. Last year the Society arranged about fifteen such meetings. In the immediate future Doctor Weld, the Editor of the Journal, will appear before the County organization of women's clubs in Suffield, Doctor James R. Miller before the Connecticut Conference on Social Work and the Secretary will address the Society of the Sons of the American Revolution. Members of the State Medical Society are urged to interest local organizations in such meetings and this office will make every effort to provide speakers.

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### Mid-Winter Dinner

The Mid-Winter Dinner meeting of the Society will be held at the Hartford Club, Hartford, on January 25, 1940. Dr. Morris Fishbein, Editor of the Journal of the American Medical Association, will be the guest speaker.

## SECTION ON Proctology

The first meeting of the New Haven Medical Society on October 4 was addressed by Dr. Richard Cattell, attending surgeon of the Lahey Clinic in Boston. Dr. Cattell presented a most interesting paper on "Carcinoma of the Colon and Rectum." The paper was discussed by Drs. Verdi, Oughterson, A. J. Mendillo, Hankin, Kleiner, and Taffel. Previous to the meeting a dinner was given for Dr. Cattell at the medical society rooms.

The Southern Medical Society will meet in Memphis, Tennessee, November 21 to 24, at which time their section on proctology will hold a session. A very interesting proctologic program has been prepared by the committee in charge.

At the meeting of the State Homeopathic Society held in Southbury on October 17 a paper on "Anorectal Examination for the General Practitioner" was presented by Dr. Simon B. Kleiner of New Haven.

Transactions of the 40th annual session of the American Proctologic Society were received during the past month. There are extra copies of

this volume available which can be obtained by communicating with Dr. Harry E. Bacon, 1527 W. Girard Avenue, Philadelphia, Pa.

The third fall meeting of the New England Proctologic Society was held October 13 and 14 in Bridgeport, Connecticut. The society was the guest of Dr. J. Grady Booe and the meeting on October 13 was held at Laurelwood Farm in Shelton. The dinner was followed by a business meeting and a round table discussion on the following papers:

Surgical Problems in Diverticulitis

E. Parker Hayden, Boston, Mass.

Common Origin of Fissures, Fistulas, and Abscesses around the Ano-Rectal Region

George S. Speare, Boston, Mass.

Impressions of Proctology in London

Andrew Taylor, Hartford, Conn.

Report of Two Cerebral Deaths Following Anal Operations

Albert R. Keith, Hartford, Conn.

Prophylactic Removal of Polyps

Simon B. Kleiner, New Haven, Conn.

Some Observations on Pentothal Sodium Anesthesia in Anal Surgery

Frederick S. Ellison, Hartford, Conn.

Possibility of Doing Primary Fistulectomy at the Time of Incision and Drainage of Ischio-anal Abscess

James E. Fish, Boston, Mass.

Saturday morning was devoted to Operative and Dry Clinics at the Bridgeport Hospital.

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### ANORECTAL TUBERCULOSIS

(Continued from Page 608)

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## STUDIES OF THE DISTRIBUTION OF MEDICAL CARE

**Creighton Barker, M.D.**

The reports on the need and distribution of medical care in the states of Kentucky and Pennsylvania have lately been received. In Kentucky the study was made by the Committee on Medical Economics of the Kentucky State Medical Association under the Chairmanship of Doctor C. C. Howard of Glasgow and published by the State Department of Health. The Pennsylvania survey, "Are the Citizens of Pennsylvania Neglected When Ill or Injured?" was made by the Medical Economics Committee of the Medical Society of the State of Pennsylvania under the Chairmanship of Doctor Francis F. Borzell of Philadelphia and published by the State Medical Society. It is dedicated to Doctor Olin West, Secretary of the American Medical Association. Both of these studies were made on a similar pattern which followed closely the recommendations of the Bureau of Medical Economics of the American Medical Association. Every County in the two states was carefully surveyed giving consideration to the topography, population, natural resources, industry and economic status of its inhabitants and the need and facilities for the distribution of medical care within each of those areas. Inquiry was made into the State participation in the fields of preventive medicine through the State Health Department, the maintenance of State hospitals and institutions for the care of the physically and mentally sick and the mechanism for the distribution of aid and care through public welfare departments. In neither of the reports have definite conclusions been drawn, they are both of them bold statements of facts that have been gathered by careful and presumably impartial study. The nearest one comes to a conclusion is found in the introduction to the Pennsylvania survey, "Granted that there are areas in Pennsylvania and throughout the United States where good medical care may not be available to all who need it, our nation nevertheless leads the world in progress as marked by sickness and death rates, and according to the United States Public Health Service this progress was greater in the year 1938 than in any previous year.

Medical service of good quality cannot be supplied cheaply. . . ."

"Until the taxpayers of Pennsylvania can provide funds to furnish good minimum medical care to the needy, it would seem to be wise for lawmakers to permit and encourage private initiative, through voluntary cooperative action as represented by the organized healing arts professions and the non-profit hospitals, to continue their leadership in the solution of the sickness problems of the citizens who are ambitious to plan for, or are capable of budgeting for sickness service."

There are many influences of geography, population concentration, industry and economics in the State of Connecticut that make it difficult to compare with the States of Pennsylvania or Kentucky. It is true that northern counties of this State are not thickly settled, but these rural areas are closely contiguous to urban centers and because of the splendid highways no part of this State is remote from ample and competent medical care. Private philanthropy has been developed to a high degree here and voluntary non-profit hospitals are scattered throughout the State, no resident lives more than twenty-five miles from a well organized and generous general hospital. People in Connecticut are relatively prosperous, except for Nevada the per capital wealth in Connecticut exceeds that of any other commonwealth and the load of poverty is not great. That improvement in the quantity and distribution, perhaps the quality of medical care, could be effected in Connecticut and make it an even better place to live in cannot be denied but the problem here is a different one and it is scarcely possible that the formulae that can be successfully applied in Pennsylvania, Kentucky and elsewhere will simplify the answer here. In these varying conditions, and they exist the country over, lies one of the basic objections to a "National Health Program." The needs and answers to needs for medical care differ so widely from state to state that the establishment of a national pattern, although theoretically desirable, might develop new inconsistencies.

Great credit is due to the Medical Societies of Kentucky and Pennsylvania for the fine contribution that has been made to the knowledge of this pressing and important subject. Connecticut congratulates them.



# Our Neighbors

## MASSACHUSETTS

Tuberculosis in Massachusetts remains the most serious of the communicable diseases. The toll of tuberculosis is between four and five times as great as the sum of the recorded deaths from all other communicable diseases excepting influenza and the pneumonias, despite the reduction of 75% in the death rate since 1900. The average duration of a case is between three and four years with an approximate cost of a thousand dollars for hospitalization. Since the peak of incidence comes between the ages of 20 and 40, the wage earner is frequently involved so the remainder of the family in many cases becomes the burden of the community thus adding to the financial and social costs of the disease.

Pope, A. C., *Commonwealth*, Jan., 1939.



## NEW JERSEY

The birth rate in this state has declined to half that of 1920. The death rate has shown a corresponding decline. Tuberculosis deaths are less than half of their number a score of years ago but sanatorium admissions remain about the same. Mental hospital admissions are also increasing, due partly to voluntary admissions for cure rather than imprisonment.

The following methods of attaining its objectives have been laid down by the Committee on Public Relations for the coming year:

1. Press releases providing news of organized medicine in New Jersey and other information relative to health and medical care.
2. Continued sending of the weekly health feature, "The M.D. Says:", to the press.
3. Distribution to legislators and mailing list of material pertaining to work of the Society.
4. Promotion of a third anti-appendicitis campaign.
5. Use of exhibits.
6. Securing radio time for special occasions and promotions of a Society radio program if feasible.
7. Continued service to physicians in providing speakers' service loan material.

8. Continuation of the function of the committee as a service agency by assisting county medical societies in the preparation of publicity.

9. Continued contact with the press and with organizations interested in health.

10. Promotion of paid institutional advertising by county medical societies.

11. A meeting of State Society's Public Relations Committee with chairmen of county medical society public relations committees in order to coordinate and clarify public relations policies of the State and county societies.

12. Preparation and distribution to physicians of information pertaining to medical economics.

The Medical Society of New Jersey, through its Committee on Traffic Accidents is cooperating with the State Commissioner of Motor Vehicles in the investigation of sudden deaths and illnesses of persons driving automobiles. The purpose of the investigation is to determine which types of persons are potential hazards to themselves or others while driving a car.



## NEW YORK

In 1938 new low morbidity and mortality records for diphtheria were established in this state, exclusive of New York City. According to the annual report of the State Division of Communicable Diseases for that year, there were reported only 163 cases and 12 deaths compared with a previous minimum of 203 cases and 22 deaths in 1937 and a previous maximum of 11,916 cases in 1921 and 1,031 deaths in 1900. With the exception of small outbreaks in two state institutions, there were no epidemics of diphtheria during 1938.

Buffalo and Batavia suffered epidemics of poliomyelitis during this autumn. Batavia was much harder hit than the larger city of Buffalo. When first reported approximately sixty per cent of the cases had paralysis.

Dr. C. W. Munger, Director of St. Luke's Hospital, New York City, speaking recently before a hospital meeting in New York State, made the following interesting observations, or rather, speculations: "Will the practice of medicine and of nursing differ, in 1960, from that of the present day? It is safe to say they will, but how? Among doctors we will have, I believe, at least an equal proportion of specialists to the present,

but trends in specialty training, already in evidence, make certain of men of superior training and probably greater skill. More of the elements of so called 'state medicine' will doubtless have entered the scene but I believe that, basically, private practice, much as we know it today, will dominate. Let us hope that the profession, having won its fight against state control, will be in a less jumpy state of mind and, through regained self confidence, will be less suspicious of those who wish to study, objectively, the health needs of the underprivileged.

"Nursing and nursing education will undoubtedly have progressed, even if only in realization of the recent advances in the educational content of nursing courses. Just how few hours the ladies will be working per week is unknown to me but I believe most of them will still be outside of the C.I.O. As a group they should be more definitely a profession than now and will be grounded in psychology in the best in ethics as well as in the branches of clinical nursing. It is safe to believe and hope, that a broader culture will be rife among them. Naturally, they will be above gossip and others of life's weaknesses including former tendencies to be fallen in love with by callow internes and male patients met at times of depleted resistance."



**Sulfanilimide and Tubercle Bacilli** — The "wonder drug" — sulfanilimide — is being modified in the attempt to make it effective against the acid-fast tubercle and leprosy bacilli, but the work does not, as yet, permit any conclusion as to the efficacy of the new product in man. It is a combination of sulfanilimide and of cocoanut oil which it is hoped will enable the drug to penetrate the waxy content of the bacilli, which has heretofore served as armor against chemotherapy. *Crossley, M L. with Northey, E. H. and Hultquist, M. E., N. Y. Times, April 7, 1939.*

## - NEWS -

### *from County Associations*

#### **Fairfield**

The sudden death from coronary obstruction of Doctor Bartholomew C. Passuth on Wednesday October eleventh was a great shock to his medical colleagues. There had been no previous warning of coronary disease and he had appeared in good health up to a few hours before death. Dr. Passuth was born in Bridgeport and after release from military service during the last war he returned to his native city to engage in private practice. He was also physician to the Bridgeport Brass Company. Dr. Passuth was an alert and active participant in the medical life of his community, remembered with respect and affection.

The Fairfield County Medical Association held its 148th semi-annual meeting on Wednesday, October eighteenth at the Hotel Green in Danbury. Following dinner Dr. Milton C. Winternitz spoke on "Infecting Agencies and Pathology."

Subsequent discussions of this general subject will be held in co-operation with the local medical societies in Fairfield county. On November 15th at Norwalk, Dr. Thomas Francis of New York will speak on "So-called Contagious Diseases with Special References to Virus Diseases." On January 18th at Greenwich, Dr. John C. Leonard of New Haven will give a paper: "The Laboratory in Infectious Conditions." In Bridgeport on February 6th, Dr. Hugh Auchincloss, New York, will present an address: "Wounds-Treatment and Complications." On March 12th in Stamford, Dr. Russell Cecil, New York, will present "Principles of Serological Treatment in Infections." Again in Greenwich on May 14th Dr. Francis G. Blake, New Haven, will speak on Modern Trends in Chemotherapy."

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(SEE PAGE 2.)



The committee is to be highly complimented on the group of speakers which they have secured for these meetings.

The cornerstone of the new Southbury Training School for mental defectives was laid on the afternoon of October 5. The Connecticut State Medical Society was represented on the program by its president, Doctor Joseph I. Linde. His Excellency the Governor, Honorable Raymond E. Baldwin, delivered the address.

### Hartford

His many friends and colleagues are glad to learn that Doctor James E. Murphy is convalescing following a serious illness.

Congratulations are extended to Doctor and Mrs. George C. Glass on the birth of Linda Evelyn and to Doctor and Mrs. John W. Larrabee on the birth of Nathaniel Larrabee, II.

At the meeting of the Hartford Medical Society, October 1, Doctor Arthur Fishberg, Associate in Medicine at Mt. Sinai Hospital, New York City, gave a very interesting and practical paper on Circulatory Failure which he divided into (1) Peripheral, due either to oligemia or deficiency of the vessels and (2) Cardiac, which he classified as hypodiastolic and hyposystolic. The various phases of each type were thoroughly described and the differences in diagnosis and treatment were outlined. Engaging in the discussion of this paper were Drs. Starr, Steiner, Brewer, Wentworth, Steincrohn, Carroll, Madden and Knowlton.

The 2nd annual public meeting sponsored by the Information Bureau of the Hartford County and City Societies was held at the Bushnell Memorial, Hartford, on the evening of October 16, before a large and appreciative audience. The speaker was the internationally known neurologist of New York, Dr. Foster Kennedy, and his subject previously announced as "Emotional Unrest in a Restless World" was changed to "Emotional Unrest in a Dangerous World." Doctor Kennedy's address consumed about one hour and while he at times rambled philosophically there was always a coherence in his ideas. The greatest force of his talk and the clearest logic were exemplified towards the end when his remarks concerned the need of man in a belief in some ultimate good, namely God. "It is very necessary," Doctor Kennedy said, "that man shall believe in some ultimate good

and make a decision to combat evil. By doing this, he will regain his own integrity as a reasoning being. There would be far less trouble in the world if it were required of nations that their relations between each other be maintained on the same level of trust and lawfulness as exists between ordinary individuals. Conduct such as that exhibited by certain Central European countries in their dealings with each other would not be tolerated between individuals in the roughest outposts of civilization." "We believe," the speaker said, "whatever we want to believe, and we will believe anything of those we hate. This is a weakening of the power of reason, and makes man the victim of his own susceptibility to suggestion."

Doctor Edward H. Crosby of Hartford was recently made a Fellow of the American College of Surgeons at a meeting in Philadelphia the week of October 15.

Tumor Clinics of the Hartford, St. Francis, Municipal and Mt. Sinai Hospitals of Hartford and the New Britain General Hospital have been approved by the American College of Surgeons.

### Litchfield

At the Annual meeting of the Board of Governors of the Charlotte Hungerford Hospital, held on October 16, 1939, in addition to the regular members, the following physicians were added to the staff: Doctor Chris. H. Neuswanger, Attending Urologist, Waterbury; Doctor Wendell C. Hall, Attending Radiologist, Hartford; Doctor Robert Walker of Cornwall.

Doctor and Mrs. Francis A. Sutherland returned on September 15 after a two months sojourn in southern and western Europe. Their return was delayed by the outbreak of the war and the experiences through which they passed were unusual and interesting.

The Litchfield County Medical Association, following a long established custom, was entertained at the summer home of Doctor and Mrs. Harry B. Hanchett at Bantam Lake at a dinner in honor of Doctor Elias Pratt. The vice-president, Doctor Roy V. Sanderson of Winsted, presided in the absence of the president Doctor Edwin G. Reade of Watertown. The toastmaster of the evening was Doctor Charles H. Turkington of Litchfield. He introduced the president of the State Medical Society, Doctor

Joseph I. Linde of New Haven, the Secretary of the State Medical Society, Doctor Creighton Barker of New Haven, and the editor of the Connecticut State Medical Journal, Doctor Stanley B. Weld of Hartford. Delegates from the County Associations were Doctor James D. Gold of Bridgeport and Doctor Herbert Thoms of New Haven. The speaker of the evening, Doctor Walter R. Steiner, read a most interesting paper eulogizing Doctor Elias Pratt who has completed more than fifty years of practice of medicine in Torrington. Doctor Pratt in response gave many reminiscences of his experience as physician, legislator, health officer and pioneer in Public Health reforms. In spite of the inclement weather, the dinner was attended by 65 members of the society and their guests, among whom were members of the medical profession from Bridgeport, Hartford and New Haven.

### Middlesex

A well attended meeting of the Middlesex County Medical Association was held at the Edgewood County Club in Cromwell on Thursday, October 12. An interesting presentation of "The Therapeutic Uses Of Recent Drugs" was given by Dr. L. S. Goodman, Associate Professor of Pharmacology and Toxicology at Yale University Medical School. An excellent dinner was served following which Dr. Charles Comfort of New Haven gave an interesting talk on "Recent Trends In Medicine." Professor Edward C. Schneider of Wesleyan University spoke later in the meeting on "Aviation Medicine," a subject in which he is very well versed.

The Central Medical Association held its first meeting of the season on October 9 at which time Dr. Paul Felt, a member of the staff at the Connecticut State Hospital, presented a paper on "Differential Diagnosis of Coma". Following the scientific session a business meeting was held at which time there was a free discussion regarding the discontinuance of the city laboratory. The following resolutions were passed:

1. That the Board of Health in a full meeting reconsider its action abolishing the Middletown Laboratory and that the Central Medical association go on record as favoring the continuation of the laboratory in Middletown.

2. That the secretary of the Central Medi-

cal Association write a letter to the Common Council stating that although the Central Medical Association, when consulted by the Common Council, approved of the formation of a Board of Health in the city of Middletown with a full time health officer, at the same time offering its full cooperation and support to this movement, the Central Medical Association feels that there has been a lack of cooperation between the Health Department and the Central Medical Association in that several matters of paramount importance to the health of the community have been put into force by the Health Department, such as the removal of the laboratory from Middletown and the establishment of financial scales for admission to Well Child clinics without consultation or advice from the Central Medical Association, both of these matters concerning the health of the community.

The secretary should also request a reply to this letter from the Common Council.

Newly elected officers of the Medical Board of the Middlesex Hospital are: Dr. G. Mansfield Craig, President; Dr. Carl C. Harvey, Vice-president; Dr. William M. Joyce, Secretary. Doctor Craig has the distinction of also being President of the County Association.

Miss Camille Porter, who for the past several years has been medical historian at the Middlesex Hospital, was relieved of her duties early this month. Miss Porter also served as librarian of the Hospital and was held in high regard by members of the medical profession. Miss Porter was serving this year as president of the Connecticut State Librarian Association and was a committee member of the national group. She was recently invited to address the Massachusetts State Society at a meeting held at the Hotel Statler in Boston. Under Miss Porter's guidance the standard system of nomenclature and recording was used and Miss Porter had received commendation for her work by Regents of the American College of Surgeons. She was also a member of a committee working toward the establishment of a New England medical historian group. The physicians of the community regret that she is no longer to be connected with the local institution and wish her success in any new venture she may undertake.

Dr. James Murphy, President of the Middletown Board of Health, was instructed by the Board to send a letter of appreciation to Doctor



Jessie W. Fisher on the occasion of her retirement as bacteriologist in the city laboratory which took place on October 1. Doctor Fisher has held this position continuously since 1917. Doctor Fisher plans to devote her entire time to private practice, specializing in diseases of allergy.

Dr. Carl P. Wagner, Physician-in-Charge of Elmcrest Manor, announces the appointment of Dr. Robert Kennedy as Assistant Psychiatrist to assume his duties on November first. Dr. Kennedy is a graduate of Yale University and Yale School of Medicine. He was formerly associated with St. Elizabeth's Hospital in Washington, D.C.

### New Haven

In the September issue of Digest of Treatment (J.B.Lippincott Co.) may be found an article by George Blumer, M.D., entitled, "On the Use of Eponyms in Medicine."

The annual report of the New Haven Department of Health for 1938 contains some interesting data. It is noted that New Haven had during the past year the lowest infant mortality rate ever recorded in that city and the lowest in 88 cities of the United States, viz., 21.6. It also had a lower maternal death rate, a lower pneumonia death rate, a lower motor vehicle death rate and a lower tuberculosis death rate than ever before. This was the eighth recent year without deaths from scarlet fever and measles and the fourth consecutive year without deaths from diphtheria. The city's appropriation for health is only about 85 cents per capita. A regulation requiring that all milk sold in New Haven be pasteurized or certified went into effect October 1, 1939.

### Tolland

Doctor Huston K. Spangler, representative of The American College of Surgeons, addressed the staff and trustees of the Rockville city hospital on Oct. 5, his topic being the hospital standardization program. Constructive criticisms were offered on the present status of the hospital and its needs, particularly as regards laboratory facilities, records and dietetic supervision.

Doctor Francis Burke has been appointed Health Officer of Tolland.

Doctor Leonard W. Levine, a native of Vernon and later resident in Hartford, has opened an office for general practice at Morris Corner in Ellington. Dr. Levine is a graduate of the University of Maryland School of Medicine and the University Hospital in Baltimore.

### Windham

Doctor Bernard Murphy of Putnam has been laid up in the Day-Kimball Hospital for several months due to a fracture of the femur.

During September, Doctor E. R. Pike of Woodstock suffered a fracture of the forearm.

The hospitalization plan seems to be popular in Windham County and is rapidly gaining in subscribers.

### Willimantic

The Tri-City Medical Society, composed of members from Norwich, New London, and Willimantic, held its first meeting of the season at the Windham Community Memorial Hospital in Willimantic, October 12, 1939, at 9:00 P.M. Doctor R. M. Yergason of Hartford, who was the guest speaker, gave an interesting illustrated talk on "Action of Muscles in Fracture Cases." The meeting was well attended and a buffet lunch was served following the lecture.

Doctor Morton Arnold of Willimantic has returned from Chicago, where he attended the annual meeting of the Academy of Ophthalmology and Otolaryngology.

Doctor Andrew Laakso, who recently completed his internship at the Hartford Hospital, has opened an office in Danielson.

## The Doctor's Office

Frederic P. Rogers, M.D., announces the removal of his office for the practice of pediatrics from 50 Farmington Avenue, Hartford, to 785 Farmington Avenue, West Hartford.

William A. Geer, M.D., has opened an office for the practice of general surgery in the Professional Building, 881 Lafayette Street, Bridgeport.



### 2,720 RED CROSS HIGHWAY FIRST AID STATIONS

A total of 2,720 Red Cross emergency first aid stations dotted the nation's important highways July 1, 1939. Equipped with materials to provide necessary immediate care to the victims of accidents, these stations are staffed by men and women volunteers trained by Red Cross instructors.

Day or night these people stand ready to give their service to bridge the gap between the time the accident occurs and the doctor's arrival. Their effective work has many times been responsible for complete recovery of victims who might otherwise have died or been permanently disabled as a result of injuries.

Red Cross activities are supported from annual membership dues, voluntary contributions and gifts. Everyone can aid in supporting these services during the annual Roll Call, November 11-30, when a nation-wide invitation to join the Red Cross is extended.

## THE RIGHT TO PRACTICE IS IN JEOPARDY

(Continued from Page 617)

be subject to seizure in a prosecution under such a statute.

Many doctors may not be directly interested in the Waterbury case. It would be foolhardy, however, to ignore the threatening significance of the result, if the Waterbury doctors were convicted. A precedent would be established for a variety of unpredictable restraints, under existing or future statutes, that would harass doctors in any field. They might be forced, by fear of criminal prosecution, to refrain from adopting any meritorious new technique that conflicts with some statute based upon obsolete and rejected dogma. If, for the sake of their patients, they risked violation of the law, their offices might be subject to search and their equipment to seizure, for evidence of their guilt. A multitude of legal technicalities might be erected against the valid progress of applied medical science.

We have tried to set forth above the underlying implications inherent in the Waterbury cases as they affect Connecticut physicians. We think they are of such magnitude that the members of our profession are entitled to be apprized of them in advance of their final determination before the Supreme Court of Errors so that if it appears advisable for the Council to pursue the matter further in whatever way seems most appropriate the opinion of the members at large may be made known to it.

—☆☆—

### FLORIDA FOOD, DRUG AND COSMETIC ACT.

Florida passed, during its 1939 session of the legislature, a food drug and cosmetic law which definitely affects the practitioner of medicine. Drugs containing aminopyrine, barbituric acid, cinchophen, dinitrophenol or sulfanilamide may be sold only on prescription signed by a physician, dentist or veterinarian.

*Jour. Fla. Med. Assn. July 1939*

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## SPECIAL NOTICES

### NEW ENGLAND SOCIETY OF PSYCHIATRY

The Semi-Annual Meeting of the New England Society of Psychiatry was held at the New Hampshire State Hospital, Concord, on October 18. Ross McC. Chapman, M.D., President of the American Psychiatric Association was the guest speaker. Listed among the officers of the Society is George Elliott, M.D., of Middletown, Connecticut, Secretary-Treasurer. Forty of the members reside in Connecticut.

The following Annual Awards are offered by this Society:—

To encourage the younger medical workers in the field of Psychiatry in New England to undertake scientific work and to publish the results of it, the New England Society of Psychiatry offers two awards, one fifty dollars and one of twenty-five dollars, for the two best papers published during the calendar year of 1939. The papers shall be judged on the basis of their scientific quality by a special examining committee and the Executive Committee of the New England Psychiatry Society.

The awards will be made and announced at the Spring Meeting of the New England Psychiatry Society.

Writers who have once received an award are not again eligible.

Applicants should send reprints of articles or the journal in which articles appear before March 1, 1940 to the Secretary of the Society, George A. Elliott, M.D., Connecticut State Hospital, Middletown, Connecticut.



### UKRAINIAN JOURNAL

From time to time the Journal receives copies of the Medical Journal of Ukraina. If there is any member of the State Medical Society familiar with the language of the Ukraine who would like to receive these journals for the purpose of review of any interesting or important articles the Editor would appreciate such assistance.

### ANNUAL CONFERENCE OF SECRETARIES

The Annual Conference of Secretaries of Constituent State Medical Associations and Editors of State Medical Journals will be held in Chicago Nov. 17 and 18, *The Journal of the American Medical Association* for Oct. 7 announces. The first session will be convened at 10 a.m. Friday, Nov. 17. All meetings will be held in the Assembly Room of the American Medical Association Building, 535 North Dearborn Street, Chicago.

Officers of state medical associations and county medical societies, and individual members of the Association who may desire to be present, are invited.



### EXAMINATIONS AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 6, 1940, at 2:00 P.M. The Board announces that it will hold only one Group B, Part I, examination this year prior to the final general examination (Part II), instead of two as in former years. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held in June 1940.

**Applications for admission to Group B, Part I, examinations must be on file in the Secretary's office not later than October 4, 1939.**

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting in Atlantic City, N.J., on June 8, 9, 10, and 11, 1940, immediately prior to the annual meeting of the American Medical Association in New York City.

Applications for admission to Group A, Part II examinations must be on file in the Secretary's office not later than March 15, 1940.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I examinations (written paper and case records) and the Part II examinations (pathological and oral).

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh<sup>6</sup>, Pennsylvania.

## • Quarto Notes •

### CARDIOVASCULAR DISEASES — THEIR DIAGNOSIS AND TREATMENT

David Scherf, M.D. and Linn J. Boyd M.D.

458 pages \$6.25  
St. Louis C. V. Mosby Co. 1939

This is not just another text-book on cardiovascular diseases as the title might imply. It is not heavily laden with electrocardiographic tracings or with interpretations of the same. There are no descriptions of highly technical circulatory tests. The authors have astutely surmised that the field is already top-heavy with exhaustive works. They seem to believe that students and practitioners may be confused rather than assisted by another tome. The purposes of the book are stated: "To supply considerable practical information by brief discussions for direct application to diagnosis and treatment without recourse to complicated methods and apparatus." How faithfully the writers have been able to carry out this ideal is best determined by reading the book.

This publication has an unusual personal flavor which is accentuated by a terse lucid and succinct style of exposition. There is an underlying reactionary tone against over-complicated mechanical devices. This is balanced by a strong appeal in favor of the older techniques of examination which have served so well in the past. Electrocardiography is almost totally omitted. X-ray findings are mentioned briefly in appropriate places. In this manner, much space is conserved for the discussion of common and often perplexing clinical phenomena such as Paroxysmal Nocturnal Dyspnea, Angina Pectoris and Pulmonary Embolism. Under these three headings, a great part of cardiac physiology, both normal and pathological is reviewed. Although this book is primarily practical, theoretical considerations are not slighted where they have a real bearing. Most of the major contributions in the investigative field are subtly woven into the fabric of discussion. In this manner, the reader is treated to a critical evaluation of a great mass of recent experimental and statistical work while being spared the laborious task of reviewing large bibliographies.

The cardiological considerations of pregnancy and surgical interventions are adeptly handled. The section on therapeutics is one of the best. The uses and misuses of digitalis are stated so clearly that this aspect alone almost justifies the appearance of this book. Many of the newer drugs receive attention whereas some of the older remedies which have been shown to be of little value are summarily dismissed. It is doubtful if a book has come off the press in recent years so well planned to fill a crying need.

J. J. Clancy

### A MONOGRAPH ON VEINS

by

Kenneth J. Franklin, D.M.; M.R.C.P.

Tutor and Lecturer in Physiology Oriel College,  
University Demonstrator of Pharmacology,  
Assistant Director of the Nuffield Institute for  
Medical Research, Oxford, England.

430 pages 45 illustrations \$6.00  
Springfield, Ill. Charles C. Thomas

This book develops the subject of veins from every conceivable aspect. Beginning with a very interesting history of medicine from Alcmaeon of Croton to William Harvey the ground work is well prepared for a general consideration of the respective roles played by the heart, arteries, capillaries and veins. Having this completed, the embryology, the anatomy, the physiology together with the pharmacology of veins is taken up individually with the greatest detail. The clinical chapter is excellent in what it presents but fails to mention the fact that now surgery has more to offer than the injection treatment for the care of varicosities of the lower extremities. This omission can be easily remedied and should not detract from the true worth of the book. Here we have in one volume with forty-five illustrations, and a most complete bibliography, the subject of veins considered as never before. Every medical library and those interested in veins should possess this book.

W. D. Scudder



### DO YOU WANT TO BECOME A DOCTOR?

by

Morris Fishbein, M.D.

Editor, Journal of the American Medical Association  
176 pages \$1.50  
New York Frederick A. Stokes 1939

The author has done a service to enquiring youth in gathering together the facts found in this volume. With the preparation for the practice of medicine becoming daily more complex, wise counsel becomes more and more essential. The entire gamut of medical education in all its phases; medical school, internship, state examining boards, specialist requirements, the accessory professions, all are covered in sufficient detail to leave very little to be desired. Individual requirements for licensure in each of the States are outlined. The general requirements of candidates for the examining boards in the specialties are listed. Even the tuition charges of all the accepted medical schools in this country and the living expenses in the various sections of the country are given.

This volume of Dr. Fishbein's should be found in the possession of every one seriously contemplating the preparation of the study of medicine, of every medical student and every interne who must plan his program of further study or select a location for practice, and of every novice in the medical family today. As a guide along the way it has no peer,



## VARICOSE VEINS

by

Alton Ochsner, B.A., M.D., D.Sc. (Hon.), F.A.C.S.  
Professor of Surgery and Director of  
Department of Surgery, School of  
Medicine, Tulane University  
and

Howard Mahorner, B.A., M.D., M.S. (Surgery),  
F.A.C.S., Assistant Professor of Surgery,  
School of Medicine, Tulane University

138 pages \$3.00  
St. Louis C. V. Mosby Co. 1939

Every once in a while there comes from the medical press, a book which because of its need, its thoroughness and completeness in handling the subject, its conciseness and readability and its conservatism in treating a commonly seen disease, becomes an almost indispensable unit in a medical practitioner's library. Just such a book have the authors achieved in their volume of 138 pages on Varicose Veins. The high incidence and frequency of this condition, its morbidity and the disability associated with it, together with the universal poor results from treatment in the past and the present high percentage of recurrences from the later methods of treatment should make this subject one of great interest to the general practitioner and the specialist alike.

For a more thorough understanding of the chapters on treatment itself, the anatomy, pathology, physiology and etiology of the condition is thoroughly discussed. The introduction is taken up with the interesting surgical history of treatment.

In preparing the reader for the rationale and principles of treatment, which are the real meat of the book, the two most important chapters, it appears to the reviewer, are those on the anatomy and the examination of the varicose vein patient. The chapter on pathology confines itself to the description of the various forms of anatomical abnormalities of the veins, calling attention to the tortuosities, dilatations, calcifications, etc., together with a histological comparison of the varicose veins with the normal. The factors which are brought to play a part in their production, calling special attention to the interesting observation of familial tendency toward varicocities, are outlined in a chapter on etiology.

In discussing the anatomy, the two main superficial venous systems of the lower leg are thoroughly described with their main branches and illustrated with plates calling attention to the system of collateral branchings between the two main superficial systems themselves and with the deep venous system.

The clinical examination of the varicose vein patient is the most important step in the entire management of the case. In fact, it is more important than the actual treatment itself because a careful examination determines largely what treatment is to be. In the discussion of the importance and significance of the Trendelenburg test, as it is best known, the authors have taken time off to give credit to Brodie, who described this test 45 years prior to Trendelenburg's original observation, and refer to it always, and rightfully so, as the Brodie-Trendelenburg test.

Perthe's test and the compression test with the other classical tests are fully described with their limitations and much space is given to the comparative tourniquet test, which they themselves devised.

The authors classify their treatment under four headings, namely, the preventive, conservative, non-operative, injection and operative treatment. As pregnancy is considered one of the major causes of varicose veins, some space is given to instruction of the pregnant woman on certain exercises and periods of rest to prevent their formation. Many contrary indications as phlebitis, infections, occlusions of the deep venous system, etc., are taken up in some detail and the conservative methods of treatment in the presence of these conditions described in detail. The various operative procedures — to mention a few, Mayo's, Madeling's, Shede's, Keller's and Babcock's operations — are described only to be condemned.

The active operative treatment of varicose veins, according to the authors, should be limited to the injection treatment alone, or to the combined ligation and injection treatment. To the reviewer, the arguments and rationale behind this belief are sound and indisputable. Much space is taken up with the wise choice of the solutions to be used in the injection.

The authors point out that many of the present failures and recurrences under this form of treatment are because the comparative tourniquet and the Brodie-Trendelenburg tests are not properly understood and applied. They point out that in performing a high ligation the upper branches must be included in the ligation or the major branches must be tied separately. They also show why a mid thigh ligation and even a low thigh ligation must be done in addition to the high ligation to shut off the collateral branchings in order to cure the condition. They explain why, if a ligation is properly performed, in conjunction with a proper injection, that the major surgical procedures are unnecessary.

In pointing out the very high percentage of recurrences (60%) where the injection treatment alone is used, they nevertheless do suggest its use in the very early type of case which does not show a positive Brodie-Trendelenburg test and where the vein is small, and also in the class of patients who refuse a ligation. Even if recurrences occur, the temporary relief is sometimes of benefit and more extensive measures can later be performed.

In treating the main complication of varicose veins, namely, the ulcer, the authors believe that no treatment of the veins directly should be undertaken until the infection in the ulcer is cleaned up. They advise rest in bed with elevation as a preliminary stage, followed by supportive treatment with bandages, recommending chiefly an Una paste boot. Vitamin B is strongly suggested to control the pain. Later skin grafting may be performed. They fail to recommend, for some reason, injection of the blood pool under the site of the ulcer, after it is cleaned up. This injection with sclerosing solution into the very center of the ulcer, locating the pool underneath, together with the injection of the vein leading into and away from the ulcer in the reviewer's experience has cleaned up many small ulcers very quickly.

R. E. Dunne.

**OFFICE GYNECOLOGY**

by

**J. P. Greenhill, B.S., M.D., F.A.C.S.,**  
**Professor of Obstetrics and Gynecology,****Loyola University Medical School, Chicago**406 pages \$3.00  
Chicago Year Book Publishers, Inc. 1939

Seldom will one feel so well repaid for the purchase and careful perusal of any volume as in the case of this book written by Doctor Greenhill. It is full of valuable information, wise counsel and the latest data obtained by experimental research in the field of gynecology. A rare combination of theory and practice is found within its covers. Although as indicated by its title it deals with office procedures, the office in no way limits the scope of the book, hospital treatment and procedures being outlined where office and hospital are with difficulty distinctly separated.

To enumerate all of the chapters and paragraphs of value would be to leave out very little of the text. Many little details in the gynecological examination which are of distinct assistance in arriving at a correct diagnosis are described. The use of the Rubin test, of hysterosalpingography and of pneumoperitoneum are clearly outlined and well illustrated. The chapter on vaginal douches, exploding as it does the old theory of the desirability of alkalinity, should be read by all, specialist and general practitioner alike. The chapter on backache is unusually good. Contraception is dealt with very thoroughly and the chapter dealing with endocrinology could scarcely be improved upon today; changes of course will be in order tomorrow, so rapidly is our knowledge increasing in this field. The closing chapter on premarital examination and advice fills a very distinct and important place in such a volume and is exceptionally well presented.

It is hard to find any flaws in this little volume, produced by a leader in his specialty. It is with more than the usual enthusiasm that we recommend its ownership to all gynecologists and obstetricians and to all other physicians whose practice includes the all important factor in life, woman herself.

**STEDMAN'S PRACTICAL MEDICAL  
DICTIONARY**

by

**Thomas Lathrop Stedman, A.M., M.D.****Editor of Twentieth Century Practice of Medicine  
and****Stanley Thomas Garber, B.S., M.D.**

14th Revised Edition

1303 pp. \$7.50 with thumb index (\$7.00 without index)  
Baltimore Williams & Wilkins Co. 1939

This very complete medical dictionary contains a copy of the Oath of Hippocrates, a medical etymology and an appendix full of valuable material, such as a table of

drugs with doses and uses, tables of weights and measures, stethoscopic abbreviations, comparative temperature scales, a list of the clinical elements, the important pathogenic microparasites, and the new anatomical nomenclature recently suggested by the Anatomical Society of Great Britain and Ireland for adoption in the Basle Anatomical Nomenclature. One of the outstanding features is the listing of the origin of all proper names applied to diseases, syndromes, etc., as appearing in the dictionary.

The physician purchasing this volume will find it a very useful investment.

**THE HEALTH INSURANCE DOCTOR**

by

**Barbara N. Armstrong A.B., J.D., Ph.D.**264 pp. \$3.00  
Princeton, N.J. Princeton University Press 1939

Coming as this book does from the pen of a legal scholar and economist as well as an ardent advocate of health insurance, it pictures this modern contribution to the social structure of many lands with a concise but distinctly pleasing touch. The short-comings of health insurance in England, Denmark and France are revealed but in such a manner that the reader must gain the impression, at least in the case of all but France, that the advantages far outweigh the disadvantages. Although many sources of material are quoted there is a dearth of first hand experiences and opinions cited from those actually practising medicine in these countries, with the possible exception of France.

By salient points of the British health insurance program are clearly outlined, its free choice of physician, its limitations within the general practitioner group, its application only to wage earners, and its payment for medical services on a capitation basis. Little is said of the quality of work produced by physicians on these panels. The Danish plan as outlined by the author appears much more attractive, including within its scope many self employed workers and providing medical and hospital care for a member's family in addition to the member himself. In Denmark membership in the medical association is a pre-requisite for entering health insurance practice. The characteristic of the French system, partial re-imbursment for a worker's expenditures on medical, surgical, and hospital care and drugs, has found both favor and disfavor in that country. Organized medicine in France has insisted upon and obtained unregulated freedom in its system of fees, believed by many to be a disturbing factor in the free choice of physician.

The volume is very lucid, contains a great amount of detail of real value and is worthy of the time of any one interested in this subject, now occupying such a prominent place in our national affairs. Scarcely a page but contains one or more explanatory footnotes or references to material utilized in compiling the information afforded the reader.



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*(Continued from Page 615)*

20. Lorretta K. Age 6, vomiting, diarrhea, head ache, pain in abdomen. Temp. 100 (M). Throat mildly red, chest clear, abdomen tympanitic and tender. Recovery in five days.

21. Ernest L. Age 5, fever, sore throat, pain in abdomen, no vomiting, no diarrhea. Temp. 101 (M). Throat mildly red, chest clear, abdomen tympanitic not tender. Recovery in five days.

22. Phyllis M. Age 5, vomiting, no diarrhea, headache, no fever. Mildly red throat, chest clear, abdomen tympanitic and tender. Recovery in four days.

23. Donald M. Age 3, vomiting, headache, no diarrhea. Temp. 102 (M). Throat red, chest clear, abdomen tympanitic and tender. Recovery in five days.

24. Bernard P. Age 7, diarrhea, no vomiting, pain in abdomen, no fever. Throat not red, chest clear, abdomen tympanitic not tender. Recovery in three days.

25. Carolyn W. Age 4, vomiting, no diarrhea, no fever. Throat not red, chest clear, abdomen tympanitic not tender. Recovery in forty-eight hours.

26. Barbara W. Age 6, vomiting, diarrhea, no fever. Throat mildly red, chest clear, abdomen tympanitic not tender. Recovery in five days.

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The third annual report of Group Hospital Service, Inc. St. Louis, covering its fiscal year ending April 30, 1939, is of some interest. At the close of the third year there were 38,074 contracts in force covering 69,182 persons. More than 1400 business and industrial firms were represented. Approximately 90% of persons enrolled earned less than \$3,000 a year and approximately 60% less than \$1500 a year. Assets were \$198,326.79; actual and potential liabilities were \$91,199.80; reserves and surplus were \$107,126.99. During the last fiscal year the Service paid \$293,879.34 to member hospitals for 64,326 hospital days. The average hospital stay was 9.08 days. Members paid the hospitals \$125,336.44 in addition to that paid by the Service. The income was distributed as follows: hospital care 62%, administration 11%, interpretation 7%, placed in reserve 20%.

*Jo. Mo. State Med. Assoc. Aug. 1939*



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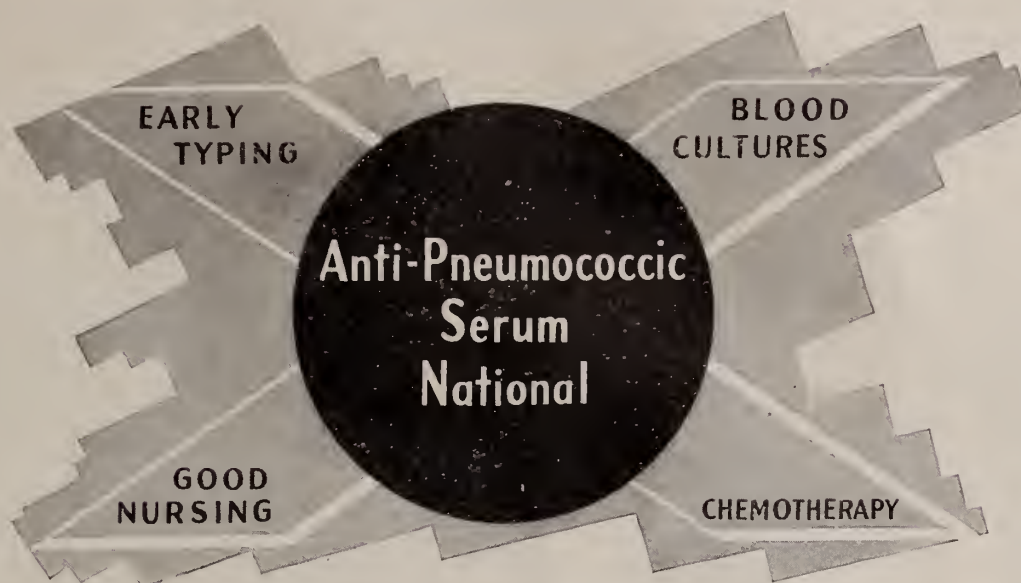
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*A bambino from the Foundling Hospital, Florence, Italy, — A. della Robbia*

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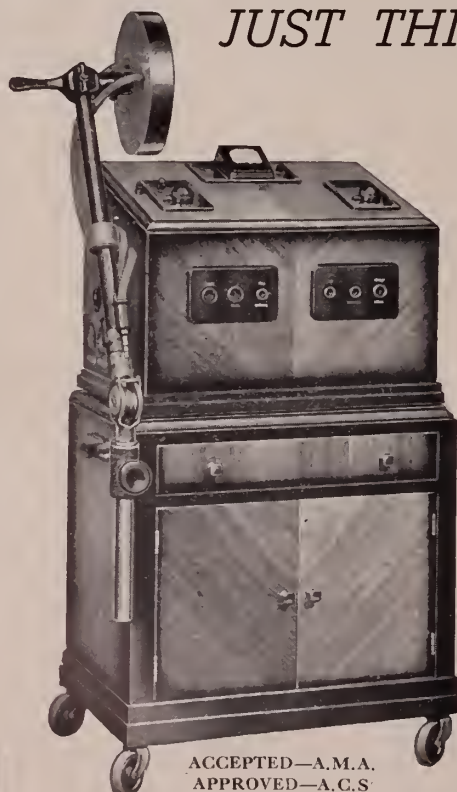
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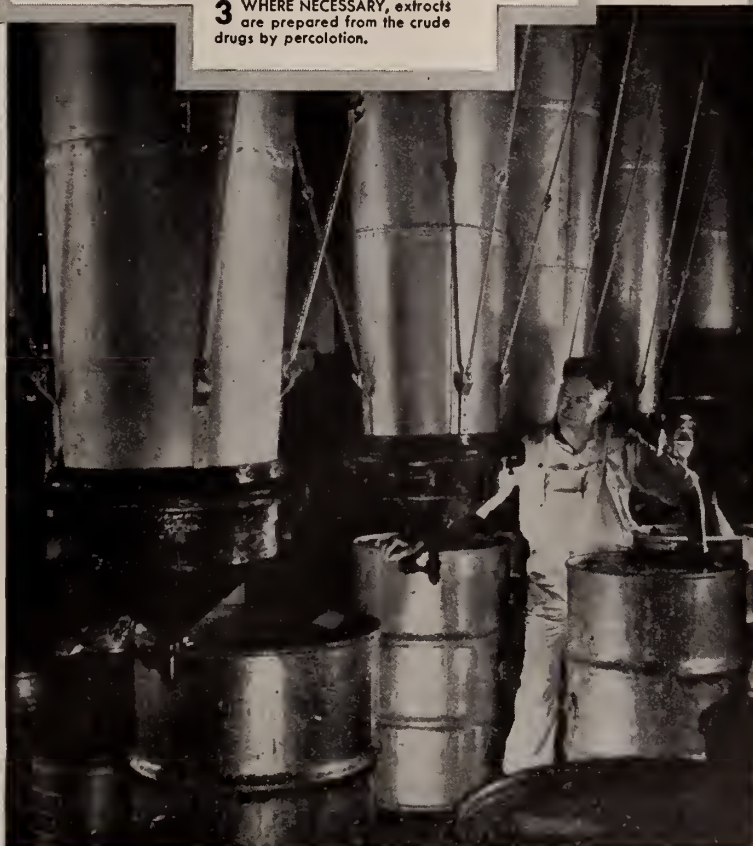
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Editor-in-Chief - STANLEY B. WELD, M.D.,  
54 Church Street, Hartford, Connecticut

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## Sulfapyridine therapy in pneumonia—

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THE USE OF SULFAPYRIDINE in the treatment of pneumococcal pneumonias is now considered fundamental.

Authorities are agreed that sulfapyridine should be employed in all cases except in the instance of the rare individual in whom the administration of the drug produces toxic manifestations of sufficient importance to prohibit its use.

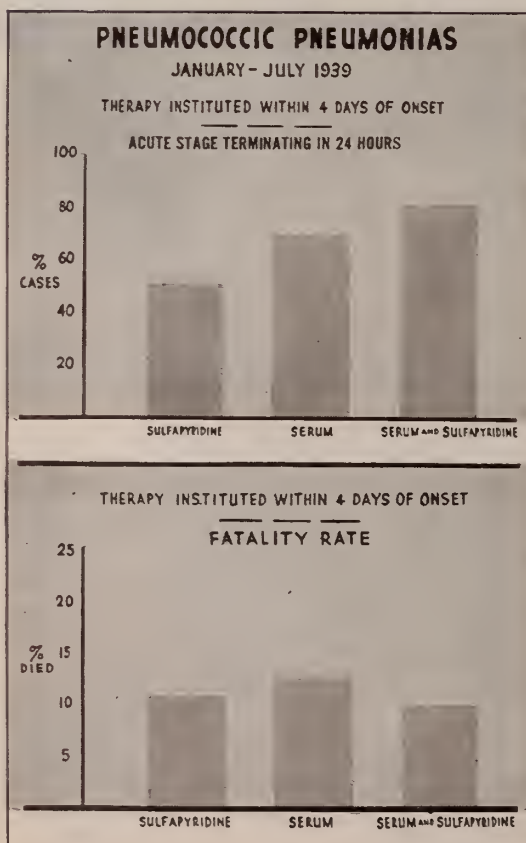
LONG and WOOD\* reported a fatality rate of 7.2 per cent. in 139 adults treated at the Johns Hopkins Hospital. The authors attributed this low death rate to the use of sulfapyridine, antipneumococcal serum, and a combination of serum and sulfapyridine. Investigators are now uniformly reporting lower fatality rates than were before thought attainable.

Toxic manifestations of the drug are similar to those described in the course of sulfanilamide therapy—central nervous system disturbances, drug rashes, drug fever, and disturbances in the red and white blood cells. Impairment of renal function is one of the most important complications.

Obtain sputum and blood cultures for bacteriologic diagnosis as a guide in treatment and aid in prognosis.

Administer sulfapyridine in adequate dosage to all cases.

Observe precautions against toxic effects of the drug by making daily urine examination, red and white blood cell count, and hemoglobin determination.



Bullowa: Harlem Hospital

\*LONG, PERRIN H. and WOOD, W. BARRY, JR.: Ann. Int. Med., Vol. 13, No. 3, Sept., 1939, Page 487.

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**President Connecticut State Medical 1923-1924**





# JOURNAL *of* The Connecticut State Medical Society

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VOL. III.

DECEMBER, 1939

No. 12

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## The Litchfield County Medical Association and Dr. Elias Pratt\*

WALTER R. STEINER, M.D.,  
Hartford, Conn.

Some years ago my friend, Dr. William H. Welch of Baltimore, your distinguished honorary member, asked me if I had ever seen a play entitled: "Edwin and Angelina." I replied in the affirmative, and not long thereafter I picked up a copy and took it over to Dr. Welch on Christmas Day at the Johns Hopkins Hospital, shortly before his death. It was by Dr. Elihu H. Smith, a native of Litchfield County, who practiced first in Wethersfield, was the first secretary of the Hartford County Medical Association and later one of the editors of the American Medical Repository, our first medical journal and also one of the first Visiting Physicians at the New York Hospital. At the time of my visit to Dr. Welch, he gave me the results of his browsings into the history of medicine in Litchfield County. Subsequently, through the kindness of Dr. Howard W. Haggard and my own researches, I was able to discover the date of the founding of your Association: July 5th, 1779. The date had been previously wrapped in obscurity. Unknowingly, Dr. Welch had written it when he copied the notice of a meeting of physicians at Sharon on the date just given from Packard's History of Medicine in the United States. Today, consequently, you are celebrating the 160th anniversary of your organization and the 50th anniversary in practice of

your former president, Dr. Elias Pratt; an honorable record for both.

Fourteen years before the organization of the Litchfield County Medical Association, James Potter, your first president, in his Presidential Address at your second meeting declared that he delivered, before the Medical Corporation of Litchfield, "A Compendium of the First Rise and Progress of Physic as far Back as History and Fable Afford Any Light Down to the Days of the Great Boerhaave." When this Corporation was organized we do not know, but it must have existed as early as 1765 when Dr. Potter delivered his oration before them, and we know from Dr. Sumner's Presidential Address before the State Medical Society that in 1766 this Corporation endeavored to form themselves into a society "for the encouragement of literature and a regular and a wholesome practice." But, unfortunately, their laudable endeavors were discountenanced by the General Assembly who refused to give them a charter. Their opposition probably was due to the fact that the quacks and the people said, "if the charter were granted, the learned men would become too rich by a monopoly as they had in England." This objection was answered without effect by the statement that "would it not be better to permit a monopoly to preserve the health and lives of the people than to suffer

---

\*An address delivered before the Litchfield County Medical Association October 3, 1939 in honor of Dr. Elias Pratt.



quacks to kill them and ruin the province?" Unfortunately, my efforts to find this charter which the doctors of Litchfield presented to the General Assembly were unsuccessful. I have had the records of the General Assembly searched without a successful result. We know from a reference in the Connecticut Courant for October 9th, 1765, that there was a tirade against this Corporation then published, claiming that it admitted quacks to their membership.

I hesitate to tell you when Dr. Pratt was born. None of you would believe it. Years ago Cicero wrote in his *De Senectute*: "For just as I approve of the young man in whom there is a touch of age, so I approve of the old man in whom there is some of the flavour of youth. He who strives thus to mingle youthfulness and age may grow old in body but old in spirit he will never be," but Dr. Pratt does not seem to grow old even in body. Suffice it then for me to say that after he prepared for a medical career by studying under some doctors in Essex, the town of his birth, he eventually matriculated at the College of Physicians and Surgeons in New York City. In 1887 he was graduated with the degree of M.D. and received an internship at the Charity Hospital on Blackwells Island. Then after a short period of practice in New York City he went as a ship's surgeon to Denmark, and finally settled down to practice on January 19th, 1889, in the Smith house, on Main Street, in Torrington. We have been informed that he has still preserved his original sign which we hope he will keep for, as has been said, it is surely a museum piece. On the day before he began his life's career, his village paper, the *Deep River New Era*, announced his intentions and predicted "as an earnest Christian gentleman that he would win the respect, confidence and love of the people with whom he had chosen to make his home." That this prediction has come true no one will gainsay.

Recently three doctors who have had a similar record of fifty years in practice have put their experiences in printed form for permanent preservation and we trust Dr. Pratt will later do likewise. I find, however, that I have been anticipated in this desire, for Mr. John H. Thompson, the Managing Editor of the *Torrington Reporter*, made a similar request in an article in his paper on October 15th, 1936. At that time he thought the autobiography might be entitled:

"The Doctor, the Legislator or the Scholar" after Dr. Pratt's name, but finally he favored this title: "Dr. Elias Pratt, a Leader in the Cause of Public Health." As a reason for this title, Mr. Thompson cites the many laws safeguarding the public health whose passage were greatly influenced during the years 1899 and 1901 when Dr. Pratt was in the legislature. These laws concerned the protection of the milk supply, the laws for clean dairies, for the elimination of diseased cattle, for the abolition of the dipper can, dead fly system of dishing out milk in public eating places and for a host of other measures. Surely Cain's question: "Am I my brother's keeper?" has ever had, in his mind, a sanitary answer in the affirmative.

But it is not during his legislative years that he has battled for these important questions. Believing, with Dr. Osler, that "it is not in the local society only that a man gains encouragement in his day's work and a betterment of mind and method," he joined in 1890 the Connecticut State Medical Society, regularly attended its meetings and became well known to the doctors throughout the State. He has been on the Committee on Public Policy and Legislation of the State Society from 1904 to 1911 inclusive, and from 1928 to 1932; being Vice-Chairman of this Committee from 1930 to 1931 and Chairman from 1931 to 1932. Matters concerning the health of the people are considered in this Committee of the Medical Society, for we realize the truth of the old Roman maxim: "*Salus Populi Suprema Lex Est*" — the health of the people is the supreme law. Besides this office he was elected the President of the State Society for 1923 — 1924, devoting his Presidential Address chiefly to a consideration of the Hartford Retreat or the Neuro-psychiatric Hospital.

He has also served your County Society as a councilor from 1910 to 1922 inclusive, and has been your president on two occasions. His many years as school examiner in the town of Torrington attests also his interest in promoting health matters there, and he has been in this position so long that "the mind of man runneth not to the contrary." One other example of his interest in preserving the health of Torrington may be given here. In 1918, during the epidemic of influenza, having been through the epidemic of 1890 and realizing that the present epidemic would certainly strike Torrington be-

fore long, he had the School Board of that town give him the High School building as an emergency hospital with the necessary organization, so that on the evening of the day when the authority for this emergency hospital was granted 35 patients were admitted. This early hospitalization of patients with this disease, with the group of nurses and volunteer school teachers acting as aids, doubtless was responsible for the low death rate in Torrington for a place of its size. Generally large manufacturing communities have higher death rates than the rural towns. This remarkably low death rate caused an assistant of Professor C.E.—A. Winslow, the Anna M.R. Lauder Professor of Public Health at Yale University, to write to Dr. Pratt at that time for an explanation of this fact. Torrington also owes to Dr. Pratt its garbage collection and its recreational facilities. He has given efficient service also to the Hartford Retreat and Neuropsychiatric Hospital as one of its Advisory Medical Board from 1907, and has acted as its Chairman from 1931.

Fifty years of practice with all of these interests is certainly commendable, for these years have been devoted, as we have seen, to matters conducive to the public weal in the promotion of health, education and other noteworthy objects. He has also been devoted to his patients during these years and the high regard paid him by the community in which he lives shows the affection it has for him. As Dr. Pratt has made good in all of these particulars, I am happy to congratulate the Litchfield County Medical Association today upon their former president for his fifty years of practice, and for the length of years which it has also attained in its 160th anniversary. May I close with these lines written by a friend of mine for another occasion and refer them to Dr. Pratt.

Long may he live to taste alike  
Of age and youth the joys;  
Old, yes, in years, but in his heart  
A boy among the boys!

## TWO AMERICAN PHYSICIANS ARE HONORED BY SPECIAL POSTAGE STAMP ISSUE

The benevolent character of the service which physicians give to suffering humanity is typified by the general practitioner of medicine and the army medical officer thus memorialized, *The Journal of the American Medical Association* for Nov. 11 says in commenting on an announcement by the Postoffice Department that the late Major Walter Reed, M.D., of the Army Medical Corps, and Crawford W. Long, M.D., of Georgia, will be among those honored in a famous American series of postage stamps to be issued soon.

"Although other names might well have been added to this brief list, no one will deny that the two selected fully merit this honor," *The Journal* says. "Our Eastern shores and many of our cities were invaded some ninety-five times by yellow fever before Drs. Reed, Carroll, Agramonte and Lazear conducted experiments in Cuba which demonstrated that yellow fever is transmitted by the bites of certain species of mosquitoes. Yellow fever had been present in the Western hemisphere for at least 300 years and had caused tens of thousands of deaths. Following this discovery by Walter Reed and his associates in 1900, yellow fever soon disappeared from North America and has never returned. Dr. Crawford W. Long, a general practitioner of medicine, on March 30, 1842, first used sulfuric ether as an anesthetic during the performance of a surgical operation. Dr. Long performed this operation on James M. Venable in Jefferson, Jackson County, Ga., a small town then many miles from a railroad."

*The Journal* of the A.M.A. called attention last year to the disparity between the number of physicians in other countries who had been honored by special issues of postage stamps and the number so honored in the United States.

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## Varieties of The Healing Process in Tuberculosis of The Spine\*

PAUL P. SWETT, M.D.,  
Hartford, Conn.

The purpose of this paper is to introduce for your consideration certain problems concerning the nature of the healing process in tuberculosis of the spine. Standard works on the pathology of bone and joint tuberculosis leave much to be desired. It is not intended to advance any conclusions concerning the pathology of spinal tuberculosis, but, rather, to suggest that much of the orthodox thinking on this subject is in need of revision. Even in so fundamental a matter as that of the question of whether or not sequestra are formed in this disease, there is not a sufficient unanimity of opinion to satisfy a clinician. Does tuberculosis of the vertebral body ever show a true sequestrum or is it true, as is generally supposed, that the dense appearing shadows occasionally seen in the x-rays indicate simple compression? This question recently was discussed in two different groups in one of our largest medical centers and both opinions were expressed with about equal force and, as far as an unprejudiced observer could discern, with about equal reason.

In the course of a study of the end results in tuberculosis of the spine, certain surprising and enlightening observations have been made which throw considerable doubt upon many of the cherished notions concerning the nature of the healing process in this disease. This study was undertaken in an effort to evaluate the relative merits of the conservative and the operative plans of treatment. For this purpose all of the available cases, treated in several large clinics during the past twenty-five years, are being re-examined and re-x-rayed. It was supposed in the beginning that by a comparison of the early with the late x-rays it would be quite easy to gain a good idea of the final healing and to compare the results obtained under the conservative treatment with those which followed



Figure 1

This shows a healed process with solid fusion between the contacting vertebral bodies and a complete loss of the intervening cartilage. This is thought to be an ideal type of healing, and therefore it serves as a model for the objective of treatment of tuberculosis of the spine.

the operative plan. Early in the course of this study it became apparent that the original idea of simply noting the extent of the fusion was not sufficient to give an adequate impression of what really had occurred in a tuberculous spine in the course of the years. That is to say it shortly became evident that healing by fusion is a term which needs definition.

The conception that healing occurs by fusion

\*Read at the 147 Annual Meeting, Connecticut State Medical Society, New Haven, May 25, 26, 1939.

of bone in the diseased area has long prevailed and this has been rather glibly referred to as the method by which nature terminates a tuberculous process. It was because of this conception that the various operative plans, which were intended to promote fusion, found such enthusiastic response in the minds of surgeons. But our cases, from the beginning of our study, showed it was necessary to define the term fusion since there were found to be several forms of this process. In some varieties it was apparent that the disease was completely obliterated and in these instances the areas formerly involved were found to be filled in with new strong bone and that such bone extended from healthy bone above to healthy bone below the site of the original disease. That is to say, there was a solid continuous bone joining together in one mass two or more vertebrae so that the effect was that of a single vertebra in the region involved. But this effect, which from our original viewpoint might be considered ideal, was conspicuous by its relative infrequency. Numerous variations from this type of healing were discovered and, while they showed many of the characteristics of fusion, it was noted that this had developed only in parts of the spine. In these instances there was not any such degree of fusion as to enable us to classify them in the same category. The following list of these variant forms may not be final nor complete but it represents the more common varieties thus far encountered.

1. Fusion of the spinous processes, usually found following an operative attack, in which there is no fusion of other parts of the vertebral column. For purposes of clarity this form has been classified as bridging of the spinous processes.

2. A deposit of new bone along the anterior surfaces of the vertebral bodies throughout the involved region without fusion of the bodies themselves and usually accompanied by a persistence of all, or parts, of the intervertebral cartilages. This form we have classified as anterior bridging.

3. Calcification of an abscess lying anterior to and contiguous with the vertebral bodies. This variant form usually is present in cases of extreme kyphotic deformity.

4. A relatively common type is found in



**Figure 2**

This figure is to be compared to figure 1, since the lesion is in the same relative region and of about the same degree of severity. However, in spite of a spinal fusion healing has not occurred. It is to be noted that the fusion has an area of pseudarthrosis.

cases of deformity so great as to be considered unrestrained. This form is marked by loss of substance of one or more vertebral bodies and by a kyphosis which is limited only by contact between the surfaces of the vertebral bodies above the lesion with the surfaces of the body or bodies below the lesion. In these unrestrained deformities there are found the following varieties of such contacts. (a). Contact between the anterior surfaces of the opposing vertebra. (b). Contact between the inferior surface of a body above with the anterior surface of a body below. (c). Contact between the anterior surface of a body above and the superior surface of a body below.

Our interest in such fantastic arrangements is overshadowed by the vast significance of the fact that such gross deformities often are accompanied by an absence of any evidence of





**Figure 3**

Illustrates a severe deformity without solid fusion in the area of destruction. This is the type of healing effort which rarely is completed and in which the disease may remain active for an indefinite period.

fusion between the contacting body surfaces. While such fusion sometimes exist it is more often the case that there is no fusion at all and the two bone surfaces are found to be simply lying in contact with each other.

5. Another variant is that in which the kyphosis is limited only by the persistence of a partially destroyed plug of vertebral body fused to the vertebra above and below but, at the same time, preventing actual contact between the two healthy vertebral bodies.

These findings naturally raise a question not only as to the definition of fusion of the spine, but also as to what can be accepted as satisfactory x-ray evidence of healed spinal tuberculosis. The dictionary definition of fusion is a "union or blending, as if melted together." Does such a union of the spinous processes with or without inclusion of the articulations, constitute fusion so far as it applies to spinal tu-

berculosis? Can it be said that fusion exists when a kyphosis has progressed to the fullest possible extent and the only blending is that which results from contact between the opposing surfaces of the deformed vertebrae? In both of these instances there remains some degree of motion in the diseased area and the question is whether the presence of any motion is compatible with fusion within the meaning of this word; or within a surgically acceptable meaning of this word. From the evidence so far available from our study it is apparent that bridging of the spinous processes with or without, an accompanying fusion of the articulations does not prevent further deformity of the spine, in children at least. It is not yet possible to give final decisions with regard to these questions but it seems important that they should now be raised in order that further thought may be applied to them. In this connection it is suggested that



**Figure 4**

This shows a lesion similar in many respects to that in figure 3. Here in spite of a bone graft healing has also failed and the deformity is about as severe as that which occurred in the case shown in figure 3 which was not operated upon.

the operations which are called spinal fusions might better be described in anatomical terms rather than in terms of the hoped for results. Thus the Albee operation might be called a spinous process bridging and the Hibbs operation might be spoken of as an arthrodesis of the articulations of the spine.

Another field which needs clearer definition is that in regard to what constitutes x-ray evidence of a cure of spinal tuberculosis. So far as our study shows it is not possible to give positive assertions in this connection. It is not yet determined whether cure results without any fusion. Nor whether a cure requires fusion throughout all of the structures in the diseased area. Nor whether there can be a cure with a fusion of only a part of the spinal structures. A tentative conclusion may be warranted to the effect that cure is certain only when there is present a complete fusion of the bones in the involved area and that in such conditions as posterior and anterior bridging the process can merely be regarded as arrested. The same tentative conclusion also is warranted in such conditions as extreme kyphosis limited only by the contact of opposing vertebral body surfaces, or by the interposition of a calcified abscess or the remnant of a partially destroyed vertebra.

In conclusion it is important to repeat that the purpose of this paper is to stimulate discussion and thought rather than to demonstrate the conclusion of a proposition. In this connection points should be emphasized.

1. The term spinal fusion needs careful definition.
2. The x-ray criteria of healed spinal tuberculosis require clarification.
3. Careful objective thinking by clinicians and by pathologists can do much to promote a fuller general understanding of these problems. But nothing will be gained by prejudice nor partisan loyalty.

## CITIZENSHIP MAY BE REQUIRED TO PRACTICE MEDICINE IN TEXAS

"Citizenship may lawfully be required by the state of Texas of an applicant for a license to practice medicine, as a condition precedent to the issue of a license, in the opinion of the district court of Travis County, Texas," *The Journal of the American Medical Association* for Oct. 14 states in an editorial outlining the ruling.

"Such requirement was held not to deprive an alien of any right guaranteed him by the federal constitution. As far as available records show, this is the first time that a court has been called on to pass directly on this question. Under the provisions of the constitution a state cannot deny to an alien the right to follow a 'common occupation under the same conditions that it imposes on citizens.' The practice of medicine, the Texas court observed, is not 'a common occupation' but is a profession impressed in many instances with semiofficial duties."

Statutes and regulations governing license to practice are summarized as follows:

Citizenship is required by statute in Arkansas, Delaware, Florida, Georgia, Idaho, Louisiana, Nebraska, New Hampshire, New Jersey, South Dakota, Texas and Wyoming, and by regulation of medical examining board in Alabama, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Montana, Nevada, North Carolina, Oklahoma, South Carolina, Tennessee, Washington, and West Virginia.

First papers are required by statute in Connecticut, Illinois, Massachusetts, New Mexico, New York, Pennsylvania, Rhode Island and Wisconsin, and by regulation of medical examining board in Colorado, Maine, Maryland, Mississippi, North Dakota, Ohio, Oregon, Utah and Virginia.

Neither citizenship nor first papers are required in Arizona, California, the District of Columbia, Indiana and Vermont.

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## Rational Therapy\*

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As a younger member of the medical society, and in comparison to some of those older in both years and experience that are gathered here, I do not presume to dictate to you precisely as to what is rational and what is irrational in the line of medical therapy. However, there are certain observations that even the beginner in medicine makes and by his very inexperience is at a loss in the selection of drugs and medication for therapy. Neither his text books nor his professors ever taught him what to do when he is confronted by the problem of making a choice between 'ALOPLECTOSE', 'AMPHOJEL', 'COLLOPHIL', 'CREAMALIN', 'KAOPECTATE', 'LACTALUMINA', or 'POMFRAX', when he is seeking an antacid or adsorbent for the treatment of a gastrointestinal disorder. At this point it may be well to state that I have no particular fault to find with any manufacturer or product that is named in this paper, and that the names used have been picked at random from the gorgeous advertising matter that is placed at my doorway each day by the postman, or from the so called authoratative statements of the detail-men that patiently trudge from waiting room to waiting room, graciously thankful for the moment granted in which to show their gaily printed pamphlets and drop their too tempting samples.

It is well for all of us to pause and take stock of medical therapy. There is much to be gained by sitting down at our desk and with paper and pencil making a list of let us say 25 or even 50 of the most useful medications that we have at our disposal. A list of drugs that you would choose if you were limited to those for treatment. It is fairly safe to say that not one proprietary one would appear on that list. On the contrary, when the time comes to prescribe we do not choose from that list quite as often as we might. What does happen? We do one of three things, we either write a regular pre-

scription and use the name of a proprietary medication in the body of it and the directions for taking it in the signature, or we write the name of the preparation on any slip of paper and tell the patient to get it at the drug store to be taken as the label states, or worst of all, we tell the patient to get a bottle of so and so and take it as directed on the label. Surely this is not rational therapy. We do not always know the contents of proprietary medications because the manufacturers can and do change the contents from time to time. As medications are approved by the Council one of the wise stipulations is that the Council be notified of any change to be made in the product. Patients come to us because they respect our superior knowledge; when we give to them a medication that is sold over the radio, the newspapers and in the popular magazines, it can hardly be said that we draw on this superior knowledge to their benefit. If it is necessary to give the sick medicine, let us not encourage selfmedication. If Mrs. Green is told to go to the drug store to purchase a bottle of Feosol for her secondary anemia, it is only a question of time until she tells her friend Mrs. Brown that she looks pale but she need not see the doctor because all he did was to tell her that. In six months poor Mrs. Brown gets no better and goes to the doctor only to learn that she has a far advanced carcinoma of the breast and not a simple secondary anemia.

A second irrationality that we frequently indulge in is the frank acceptance of the word of the salesman on the value or the use of the particular preparation that he is pushing at that particular moment. One needs to read the scientific literature in only a skimming manner to quickly perceive that many of the claims are not always justified and that frequently extravagant claims are backed up by testimonials that would make those exposed by the A. M. A. appear to be amateurs in the game. On the

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the other hand, salesmen from some of the larger and more reputable drug houses can frequently give us much in return for the few moments in time that they ask and their story is well worth the intrusion. We must be careful to separate the wheat from the chaff.

A third irrationality that we succumb to is the too frequent vacillation from one drug to another without giving the medication a fair trial. I believe that this happens most often in medical ward practice where it is a case of too many cooks spoiling the hash. Much of this can be eliminated by a few judicious words to the interne on the case and, once a sensible course is mapped out, staying long enough on that course until it is proven. Perhaps we are inconsistent in medications used; for example, it is usually fairly easy to find a patient carefully placed on a salt free diet but receiving a medication containing the sodium radical. This again is frequently due to a misunderstanding between those in charge of a patient. It is often difficult to refrain from prescribing any medication at all. Rest, adequate diet and fluids are frequently the necessary treatment but in order to satisfy a desire to 'do something' a great rigmarole of medications is indulged.

The prescription of reasonable amounts of medication to suit the needs of the case is not only rational but may actually measure the difference between success and failure in therapy. It is useless to prescribe twenty tablets of ferrous sulfate, grains three, to take one t. i. d. and expect to cure a secondary anemia. It is irrational to prescribe a half a pound of bismuth powder for a patient with a simple diarrhoea caused by a food intoxication. However both of these prescriptions recently came to my attention. On the one hand the physician failed to complete a good job in that the patient did not get rid of the anemia and on the other the patient was cured of the diarrhoea but was left with almost \$2.00 worth of bismuth in the medicine chest. The size of the dosage is even more important than the amount of the prescription. After taking stock of the synergistic action of drugs, let us compose our prescriptions in such a manner that the dosage of the individual items is neither too small nor too great to fail in the effect desired. Why compound a 'tonic' for a patient with a failing heart with the equivalent of 0.05 gm. of

digitalis per day and hope for good results, or expect to control a case of macrocytic anemia with one U.S.P. unit of liver given every two or three weeks. Why do we see patients that tell the story of having received 'six shots in the arm and six in the hip' and then being told that their blood test was negative and that further treatment would be unnecessary? With medical therapy let us resolve to be consistent, to be rational, and after we have made a careful examination, a good diagnosis, put more than a little thought into the prescription and finish the job so well started. This brings us to the matter of the prescription itself. Aside from the date, the name, age and address of the patient, all which should be carefully made out, let us carefully write the body of the prescription. In the body of that prescription let us use more preparations from the U.S.P., the N.F. and the Pharmaceutical recipe book. If these are lacking in preparations that are rather special in composition, and it is necessary to use proprietary compounds, write in the chemical or standard names of these, modified if you will by the name of the manufacturer or brand following. For example, Colloidal Aluminum Hydroxide 'Crooks' is better than 'Lactalumina.' Keep in sight the chemical or the drug, its action, its value and place the fantastic trade name in the background. As the Council accepts drugs it tries to eliminate confusing and non-descriptive names from the sea of tongue twisters. If the chemical name of para-amino-benzene-sulfamide is too much to use, a short substitute is in order and the Council gives us Sulfanilamide. By writing for this as 0.33 gm. it is beyond the recognition of inquisitive patients who are well aware of the 5 grain terminology. The large mass of proprietary preparations are not on the accepted list and therefore still bear the tongue twisters and nondescriptive names that are used by us until even they become by-words in every house and drug store and the preparation comes to enjoy a wide spread unsupervised use. Think for a moment of some of the more popular cathartics that found their start 'never advertised to the laity' by the manufacturer but by the unsuspecting doctor who passed the word along. Our prescription druggists are responsible members of the community, they carefully carry out your orders on the pres-

*(Concluded on Page 705)*



## Vaccines of Value\*

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In attempting to discuss the general problem of "vaccines of value" it is my purpose to use the word "vaccine" in its broadest sense and also to deal only with its use as a prophylactic agent. Obviously, the entire problem cannot be covered in a few minutes. I shall endeavor to devote most of the available time to the procedures the values of which are contraversial.

### Diphtheria

Active immunity to this disease can be produced in eighty-five to ninety-five per cent of infants and young children. It is induced by one injection of one cubic centimeter of alum precipitated toxoid or, preferably, by two or more injections of non-flocculated toxoid. This immunity develops over a period of six months and can be demonstrated by the use of the Schick Test. This protection persists indefinitely in a large majority of individuals, but should be demonstrated by Schick Tests repeated at four year intervals or when exposure to the disease is suspected.

### Smallpox

Protection against this disease is afforded through the giving of a localized attack of cowpox. Lymph from an immune bovine, or a vaccine prepared from a cultured virus, can be used. Vaccination should be repeated at five year intervals, or in the presence of an epidemic. This is one of our most reliable prophylactic procedures.

### Scarlet Fever

Reports concerning the prophylaxis of this disease are conflicting and inconclusive. In a series of 3000 individuals in Illinois, by means of five graduated injections of toxin at weekly intervals, ninety percent were rendered Dick Negative. Constitutional reactions occurred in ten to twenty percent of individuals. The duration of the immunity was not checked. This and other reports seem to show that rendering individuals Dick Negative has greatly reduced

the incidence of the disease in selected groups. It is well recognized, however, that Dick Negative individuals remain susceptible to throat infections with the scarletina streptococcus. A justifiable conclusion would seem to be that scarlet fever immunization is desirable for special groups but that its general use as a public health measure is contra-indicated because of the reactions and uncertainty regarding the protection afforded. Passive immunity to the disease can be established by the use of convalescent serum. This serum should be injected shortly after exposure and in adequate amounts. This protection persists for only a ten to seventeen day period. Modification of an attack, with a reduction in the incidence of complications, may occur if the convalescent serum is administered later in the incubation period, or in the early stages of an attack.

### Whooping Cough

Interest in the prophylaxis of this disease was revived by the work of Sauer. This investigator has used a suspension of whole killed *Hemophilus pertussis*-ten billion per cubic centimeter. Four thousand children from six months to three years of age were injected over a nine year period. The total dosage was eighty billion organisms divided into weekly injections. Sauer felt that complete protection was induced in a very large percentage. He emphasized, however, that the relationship between a positive agglutination test or a positive complement fixation test and immunity had not been established, and that the ultimate standard of efficacy must be the behaviour of the individual. In this connection we must remember that the reactions of individuals to this disease varies so greatly that it is difficult to reach any conclusion on a clinical basis only. Numerous investigators have tried to duplicate Sauer's work but with less satisfactory results. A recent report from The New York City Department of Health failed to demonstrate any essential

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difference in the incidence of pertussis in the vaccinated and control groups. It emphasized the necessity of employing a total dosage of at least eighty billion bacteria. The vaccine must be prepared from a freshly isolated strain of organisms. Krueger has advocated the use of a filtrate of a suspension of ground organisms. The use of other types of vaccine would seem entirely unjustifiable. From a very limited personal clinical experience I cannot feel that the desired results are obtained by any type of vaccine yet available.

### **Anterior Poliomyelitis**

The epidemic of 1931 stimulated greater interest in this disease. Brodie, working with a formaldehyzed virus, claimed to have successfully immunized laboratory monkeys. Kolmer presented similar claims for a virus attenuated through the use of sodium ricinoleate. A widespread demand for a vaccine, capable of producing active immunity, followed the reports of these investigators. Several thousand individuals were vaccinated with either the Brodie or Kolmer type of vaccine. In October 1935, The American Public Health Association, feeling that insufficient knowledge was available concerning the effect of such injections, strongly deprecated the use of these vaccines. Kramer and many others have been unable to verify the results of the original investigators. The difficulty is to attenuate the virus so as to render it harmless and yet to retain its properties as a prophylactic agent. This problem remains unsolved.

### **Tetanus**

From a prophylactic point of view this disease constitutes a real problem on account of its high mortality and because of the ever present question of when to give specific prophylaxis. The use of tetanus toxoid was first reported from France. It has been compulsory in the French army since 1936. Three injections at weekly or monthly intervals are advised. A satisfactorily high titer is quickly established. The immunity thus induced may not be of long or certain duration, but it has been demonstrated that an additional injection of toxoid at stated intervals, or at the time of injury, raises the antitoxin level within a few days. This increase is comparable to that resulting from the injection of 1500 units of antitoxin. Thus, the use of

tetanus toxoid for immunization may be advisable for certain groups, but the need for some test of the state of immunity other than the titration method must be emphasized.

### **Tuberculosis**

Interest in the prevention of this disease centers around the possible use of B C G vaccine. Calmette, from 1908 to 1921, using an ox bile-potato medium, transplanted a strain of bovine tubercle bacilli two hundred and fifty times. The bacilli were rendered avirulent but were still capable of producing sensitiveness to tuberculo-protein of the tissues of the animal body into which they were introduced. This finding has led to attempts to immunize children who were likely to be exposed to tuberculosis. Various methods of administration have been devised. An effort is made to keep the tissues sensitive enough to react definitely to tuberculin. The reports from various parts of the world are very conflicting. Successes and failures have been reported, both with animals and human beings. The danger is that, due to changes in environment, the virulence of any given strain may be restored. Much further work and the passing of many years will be necessary before definite conclusions can be drawn concerning the result of introducing avirulent living tubercle bacilli into the human body.

### **Respiratory Tract Infections**

Numerous studies aimed at the prevention of the ever present respiratory tract infections have been undertaken. A report from Brooklyn, dealing with infants and young children, using a commercial catarrhal vaccine and a non-specific vaccine in a control group, demonstrated an apparent reduction in the duration and frequency of the infections. Very small groups over only one year were followed, however. An earlier report from The University of Pennsylvania showed fifty percent improvement in the severity and duration of the attack but not in the frequency of the infections. The most recent report in the literature, dealing with university students, failed to demonstrate the value of respiratory vaccine given subcutaneously or intradermally. Respiratory vaccine, if it is to be used, probably should be administered in a series of eight weekly injections followed by monthly ones for the remainder of the season.



## X-Ray Fallacies\*

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There are a number of situations which constantly recur in the treatment of patients with malignant disease with which the radiologist must cope. Certain opinions seem to be commonly held by those physicians who only occasionally have reason to refer patients for radiation therapy. An attempt will be made to evaluate these ideas and to state the opinion of the radiologist in regard to them.

Radiation therapy has made great strides in the past twenty years and especially the last ten years. X-ray was used therapeutically, as well as a diagnostic agent, soon after its discovery forty three years ago. Its administration in the first ten years was entirely empirical. During the second decade, serious thought and study was given to the problem. The third decade was marked by a rapid accumulation of clinical and experimental data by physicians and physicists. In the last ten years it has become a standard form of treatment and we have seen most of our hospitals, not previously so equipped, install x-ray therapy apparatus. The progress of radium therapy has followed a somewhat parallel course. There has been a distinct difference, however. From 1920 to 1930 radium was used extensively in a great number of situations, but from 1930 to the present time it has become evident that the value of radium is limited to certain lesions involving the skin and the body orifices and cavities. This is reflected in the fact that while radium sold for \$125.00 a milligram in 1918, it can now be purchased, in large quantities, as was recently done by the federal government, for \$25.00 a milligram, or in smaller amounts for \$35.00.

Much credit must be given to physicists who have specialized in correlating radiation physics with clinical data. They have agreed upon an international standard of measurement of x-ray energy called the Roentgen or R unit. At present radium radiation cannot be measured

by this standard. Physicists anticipate the day when both x-ray and radium radiation will be classified and correlated by the same standard of measurement.

The R unit measures quantity and not quality. One must not confuse the large number of R units in a dose of low voltage unfiltered x-ray, used in superficial lesions, with the smaller number of R units in a dose of high voltage, heavily filtered x-radiation used in treatment of deep seated lesions. R units express the amount of energy delivered to the skin surface. No satisfactory method, that can be used in general practice, has been devised to determine the dose delivered into a tumor in the depths of the body. An enumeration of some of the factors involved in such a determination will explain why this is true. Some of the important ones are: the size of the portal exposed, the number of ports used, the dose in R units on the skin per day, the frequency of treatment of a given port, the total dose per port, the exit dose on the skin opposite the port, the distance of the tube from the skin, the filter employed, the voltage across the tube, and the wave length of the x-ray beam. However, accumulated clinical experience allows radiologists to estimate effective dosage by a consideration of all of these factors. In reporting x-radiation in tumor clinics, the statement of doses in R units alone is not sufficient and information on all the other variants should be supplied.

About ten years ago a Frenchman, named Coutard, popularized a technique with which he and other observers had been experimenting, called "the fractionated dose method." Before that time, massive doses, as large as the skin would stand, were given in one or two exposures. These investigators found that by giving approximately one-third of a massive dose to one port every second or third day for three weeks, the skin would tolerate three or four times the

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previous limit. Using multiple small ports the tumor could be given a greater dosage than ever before. Because of this method, clinical results have constantly improved and tumors in areas previously resistant have been successfully treated. Many lesions, previously treated by radium, are now better controlled in this manner. If radium is used, it is employed as an adjunct to supplement x-ray and increase the tumor dose in a localized area.

Insurance companies still charge radiologists ten times as much as other practitioners for malpractice insurance, because of unfortunate experiences before the days when x-ray machines could be calibrated in R units. Today, when the fractionated dose method is used, effective dosage is frequently not obtained until a sharp reaction has been produced in skin and mucous membranes. This is a necessary sequel which heals rather promptly when treatment is terminated and is an indication that the radiologist has made an attempt to deliver a lethal dose to the tumor. When such reaction is encountered, one should not carelessly refer to it as an x-ray burn.

Radiation sickness causes much discussion. The referring physician may attribute any disturbance the patient may have, either at the time of the treatment or for some time thereafter, to this condition. Roentgen sickness may occur after a relatively small dose and may not occur after large doses. No constant etiological factor has been found. In patients undergoing this treatment there is always an attendant nervous strain and there are many psychic influences at work. Therefore, it is considered better practice not to warn a patient to expect anorexia, nausea and vomiting. Then, if such symptoms do occur, they may be more correctly analyzed and treated. One distressing result is the number of patients who apply late for treatment, with the excuse that some friend has frightened them by recounting exaggerated experiences, not of his own, but of some other person, with radiation sickness.

There are several other generalizations which should be considered. Most patients do better if they are not informed that they are suffering with cancer. The mental strain and despair which result from this knowledge, are difficult to combat. Exceptions may be made where proper treatment is refused, or in the case of a

head of a family, where legal affairs should be straightened, or when a five year cure is reasonably certain, or when a five year cure has been obtained and the patient is free of disease. On the other hand, some responsible member of the family should be fully informed at all times. Prognosis should be stated as accurately as possible. A common error in advanced cases is in attempting to estimate the exact time interval to termination.

There are many situations where radiation therapy may be more or less standardized, as suggested in Connecticut Tumor Clinic Proceedings. Nevertheless, each case must be studied and variations in some of the factors of treatment are almost always necessary. The indications for pre-operative and post-operative irradiation are not yet decided. For example, in breast malignancy, pre-operative radiation is still experimental, while post-operative radiation is not used by all surgeons. In stage one, the surgeon cures seventy percent without the aid of radiation. Probably one-half of the remaining thirty percent, who are not cured, die of distant metastases, which would not have been influenced by radiation had it been given, so possible benefit could be expected in only fifteen percent. These figures are only approximate and would vary in other stages of the disease. It would appear logical, from Healey's work, that pre-operative radiation should be given in pelvic cases whenever malignancy of the body of the uterus or ovaries is suspected. Most clinics now approve of radiation sterilization in breast malignancy patients who are still menstruating.

The radiologist is frequently importuned to give a small amount of x-ray once or twice a week, or to treat a hopeless case, just because it will do no harm. The standing of such a potent and essential agent should not be endangered by such procedure. The surgeon recognizes inoperable cases, and the radiologist should be allowed to exercise judgment in the same way. Treatment in terminal stages of the disease causes public reaction against the method.

Most cases of malignancy in our tumor clinics are now studied in detail, including history, physical examination and biopsy. On this basis proper surgical and radiation procedures can be



selected. Radiation not based on such exact diagnosis is ill advised. In general, only areas known to contain malignant disease should be treated. There is evidence to show that so-called prophylactic irradiation is not usually given in sufficiently large doses to be effective.

The radiologist desires the constant co-operation of the attending physician and surgeon. The physician should supervise the general supportive treatment and the sedation when indicated; the surgeon should watch for and treat any surgical complication which may arise. All may thus contribute to the care of the patient, rather than merely to the treatment of the disease.

The economics of radiation is not well understood. On the part of the hospital, there is need for adequate quarters and expensive equipment, which requires frequent repairs and replacements and maintenance of a trained technical staff. The radiologist must devote considerable time to professional consultation, family conferences, actual treatment, frequently daily for two to four weeks, and follow-ups over a long period of time. In addition, he must keep himself constantly informed of new methods. An outstanding radiological group in Washington, D.C., announced recently that two and one-half times as many man-hours were required in therapy to earn one dollar, as were required in x-ray diagnosis. This is also true in Connecticut. The fact that a majority of cancer cases are indigent or near indigent has a decided influence on this.

To summarize, radiation therapy is a modern, well-established, essential and reasonably successful method of treatment for selected cases. There should be cooperation between the referring physician, surgeon, pathologist and radiologist from the first consultation throughout the course of treatment. Both patient and family should be handled with care and consideration. The patient must be supported physically and mentally. The family should be properly informed at all times. The prognosis must be guarded and the follow-up extend over a long period. Often the only remuneration is the satisfaction of a job well done. Understanding of these fallacies by the general profession would eliminate many of the difficulties of the radiologist in the care of his patients suffering from cancer.

### RESPIRATORY INFECTIONS ARE RELATED TO RHEUMATIC FEVER IN CHILDREN

A close relationship exists between acute infections of the upper respiratory tract and the first attack of, as well as recurrent, rheumatic fever in children (joint inflammation, which may affect the heart), T. Duckett Jones, M.D., and John R. Monte, M.D., Boston, assert in *The Journal of the American Medical Association* for Sept. 2. They base this belief on a study of 749 patients with rheumatic fever.

Drs. Jones and Monte found that "infections of the respiratory tract preceded 58 per cent of the first attacks of rheumatic fever, and of these precipitating infections two thirds (66 per cent) were sore throats. On the other hand, more than one third (37 per cent) of the first attacks were apparently clinically spontaneous attacks of rheumatic fever. However, blood studies indicate that a hemolytic streptococcus (capable of dissolving the red blood cells) infection was associated with most of the first attacks of rheumatic fever, whether or not there were preceding symptoms involving the respiratory tract.

"In patients in the inactive stage of rheumatic fever, recurrence of the fever is precipitated in approximately one half of the instances by sore throat and in almost one third by colds. In general, regardless of the age of the patient, the chance of a recurrence subsequent to an infection of the respiratory tract decreases as the period of the inactive phase of the disease increases.

"Of 271 observed recurrences of rheumatic fever, two thirds (67 per cent) were clinically associated with infections of the respiratory tract, while one third (29 per cent) were apparently spontaneous. The remaining twelve recurrences (4 per cent) followed infections or injuries outside the respiratory tract."

In discussing Drs. Jones's and Monte's paper William D. Stroud, M.D., Philadelphia, states: "In treating these children with latent rheumatic fever we have a job similar to the treatment of active tuberculosis but in a reverse manner; that is, those who come in contact with patients whose sputum is positive for tuberculosis should be protected from infection, whereas we must protect children or young adults with inactive rheumatic fever from those around them who are carrying latent or active infections, especially in the nose and throat."

## The Apical Cavity in Pulmonary Tuberculosis\*

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Multilocular or single cavities in the extreme apex of the lung always have been and still are the most difficult problems to contend with in collapse therapy. While cavities at the hilum or base also offer at times considerable difficulty in being collapsed, fortunately their incidence is not too common.

Three factors must be taken into consideration which are of extreme importance in the eventual outcome or successful result. First: the cavity itself, whether its wall is soft and lends easily to closure or whether the wall is hard and epithelialized and rigid resisting most forms of collapse therapy. Second: The mediastinum, whether it is fixed thus making a stiff counterpart against which the lung may be compressed or whether it is non-resistant and shifts easily. Third: The mechanical technique of the operation itself.

There are nine forms of collapse therapy which may be utilized and it is my feeling and I believe the feeling of my associates that the simplest procedure which will effectively result in the closure of the cavity should be first used. In some cases several different procedures are carried out before the ultimate result is acquired.

Artificial pneumothorax still continues to be the most popular procedure used and in a large number of cases results in the closure of cavities providing a selective collapse may be obtained over the cavity bearing area of the lung. Too frequently when it is found that artificial pneumothorax is unsuccessful, in that, the cavity bearing area still remains uncollapsed and the collapse obtained is over the undiseased portion of the lung, its use is continued until complications arise some of which may be life-taking or at least disastrous. Frequently an unsuccessful pneumothorax case may be converted into a successful one by a closed pneumonolysis operation as is demonstrated by slides, however, at times, the adhesions contain lung tissue, blood vessels or are so extensive that their severance is

unjustified. Some cases have been successfully converted by the combined use of artificial pneumothorax and phrenic nerve paralysis. If, however, this is not possible, the case should then immediately be considered for some other form of collapse.

A moderate number of successful results have been obtained by phrenic nerve paralysis, either temporary or permanent. I do believe, however, that if a temporary nerve paralysis is successful in closing the cavity that it should be converted into a permanent paralysis before mobilization of the diaphragm recurs. The temporary procedure has been of great help in that it allows one the opportunity of finding out whether or not the procedure is to be successful without permanently paralyzing the diaphragm in event of its failure. Open pneumonolysis in the hands of some writers has been successful in some cases, however, this has not been the case in our series of open operations which have either been followed by empyema or the development of adhesive pleuritis and an obliteration of the air space. A comparatively new procedure which was developed in Europe and has been used to an even greater extent in America is extrapleural pneumothorax. I believe that a very definite note of warning should be sounded regarding this procedure because of the fact that no case has been reported which has gone through to termination. Complications have been reported by some, such as hemorrhage, mediastinal shift, empyema, rupture into cavities and I have no doubt that when all series have been reported that there will be a question in the minds of many of us whether or not this procedure is justified. At the present time its real value is entirely speculative.

Plombage by the use of either muscle, fat, paraffin or rubber bags, while in some cases has proven successful is rapidly falling into disuse principally because at the time of operation the amount or size of the plombage necessary to

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close the cavity cannot be estimated. Oleothorax because of its very limited indications is rarely used in the attack upon apical cavities and the resulting hypertrophy of the pleura complicates and makes more difficult their subsequent closure by other means. If all the above methods fail, thoracoplasty is the most satisfactory remaining procedure. In a report made by myself two years ago in the American Review of Tuberculosis on "200 Consecutive Thoracoplasties", 78% of cavities were closed by this method. The most important contribution which has been made in thoracic surgery in recent years is that of Semb's apicolysis, numerous modifications of the operative technique have been contributed, but essentially, the fundamentals remain the same. Following the removal of the whole of the first and second and a part of the third rib, the endothoracic space is picked up through the periosteal bed and the cavity bearing apex of the lung is separated from the dome of the hemithorax and very carefully stripped down as will be shown by slides. This procedure has resulted in the closure of a large number of extensive cavities. Following the stripping of the top of the lung downward, the space is filled with saline solution and the wound closed which keeps the apex collapsed sufficiently long for thickening of the pleura to develop, thereby, in most cases preventing its reexpansion. It has become the custom in a number of clinics to routinely do this operation in all cases which I believe is a mistake and should be used only in those cases in which cavities appear at the apex. This operation is not performed without risk and it does not seem to be advisable to expose the patient to unnecessary risk when the ordinary form of thoracoplasty can be successfully carried out.

### Conclusion

1. Several forms of collapse therapy may be utilized in closing apical cavities and the proper selection of the procedure will in most cases effect their closures.

2. When a procedure is found inadequate and the result originally hoped for is not obtained, the procedure should be abandoned before complications arise and a more radical procedure adopted.

3. Extrapleural pneumothorax should proceed with great caution and should never be used in place of thoracoplasty.

4. Apicolysis should be used only when the cavity is in the apex of the lung or, at least, should not be used as a routine measure,



### THE APPRENTICE SYSTEM AND BEDSIDE TEACHING

A hundred and more years ago students were admitted to the wards of the hospitals in London. There were different grades of these hospital students: (i) the surgeons' apprentices (for the physicians did not have them) had special privileges, such as a recognized claim for vacancies on the permanent staff, in return for the premium, £300 to £1000, they paid; (ii) surgeons dressers who paid much less (about ten guineas a century ago, Paget), and (iii) other students who "walked the hospital," but without any claim on particular members of the staff. Sir James Paget (1814-1899) who entered St. Bartholomew's Hospital in 1834 as an ordinary student, wrote: "There was very little active practical teaching in the wards or by clinical lectures (in medicine); it was customary to think it sufficient to give opportunities for learning to those who could learn by looking on." Peter Mere Latham (1789-1875), physician to the hospital, he described as coming down to the hospital at 8 a.m. three times a week and giving real bedside teaching, but added that otherwise there was very little else of what could be called clinical teaching of medicine.

Before the apprenticeship in general practice was abolished by the Medical Act 1858 there must have been considerable opportunities of bedside instruction given by the practitioners to their apprentices. No doubt the amount of instruction thus provided would have varied in accordance with the character of the individual practitioner.

*Proc. Roy. Soc. Med., July 1939*



### GLASS BRICKS

Glass bricks are now being used for the outside walls of operating and delivery rooms in hospitals. They have been found to save coal and to prevent condensation and frosting as on the ordinary window. The cost of glass brick in place is about the same as that of a thirteen inch brick wall, lathed, plastered and painted. The maintenance cost is practically nihil.

# Sulfapyridine in the Treatment of Pneumonia<sup>\*†</sup>

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Following the report by Whitby,<sup>1</sup> in May 1938, that sulfapyridine was an effective chemotherapeutic agent against pneumococcic infections in mice, this compound has been rapidly submitted to extensive clinical trial in pneumococcic lobar and other types of pneumonia in man. Already numerous highly favorable reports,<sup>2</sup> which will not be reviewed in detail here, have appeared. As frequently happens with the introduction of a new therapeutic agent, these early reports have, for the most part, emphasized the undoubted efficacy of sulfapyridine, somewhat at the expense of the problems involved and the untoward reactions encountered in its use. Since it is important that these be fully appreciated it is our purpose in this paper merely to summarize briefly the results that have been obtained in the treatment of 128 cases of pneumonia at the New Haven Hospital between Nov. 30, 1938 and May 1, 1939, and to discuss in more detail some of the problems encountered in the use of sulfapyridine.

The material consists of 93 cases of pneumococcic lobar pneumonia, of which 60 were treated with sulfapyridine alone, 33 with antipneumococcic serum and sulfapyridine; 1 case of beta hemolytic streptococcic pneumonia with empyema; 6 cases of staphylococcic pneumonia and 28 cases of bronchopneumonia of variable etiology, 12 in infants, 16 in adults. No patient with pneumonia treated with sulfapyridine has been excluded from the analysis of results.

The bare data concerning the 93 patients with pneumococcic lobar pneumonia are shown in Table I.

The occurrence of only 3 deaths among the 60 patients treated with sulfapyridine alone and only 6 in the total group of 93 cases certainly speaks encouragingly for the value of sulfapyridine in pneumococcic lobar pneumonia and is confirmatory of the favorable reports of others. This favorable result becomes even more striking when it is pointed out that there were no deaths in the 76 patients under sixty years of

TABLE I. Pneumococcic Lobar Pneumonia

Pneumococcus Type	Treated with sulfapyridine			Treated with antipn. serum and sulfapyr.			Total		
	Cases	B.C.*	Died	Cases	B.C.*	Died	Cases	B.C.*	Died
I	9	3	0	12	4	0	21	7	0
II	0	..	..	3	1	0	3	1	0
III	11	0	2	0	..	..	11	0	2
IV	6	1	1	4	0	1	10	1	2
V	5	1	0	4	1	0	9	2	0
VI	2	0	0	0	..	..	2	0	0
VII	3	0	0	4	2	0	7	2	0
VIII	2	0	0	4	2	1	6	2	1
XII	1	1	0	0	..	..	1	1	0
XIII	1	0	0	0	..	..	1	0	0
XIV	9	0	0	1	1	1	10	1	1
XV*	11	0	0	1	0	0	12	0	0
Total	60	6	3	33	11	3	93	17	6

\*From the Department of Internal Medicine, Yale School of Medicine and the New Haven Hospital, New Haven, Conn.

†Presented before the 147th Annual Meeting of the Connecticut State Medical Society, New Haven, Conn. May 25 and 26, 1939.



TABLE II. Data on Fatal Cases of Pneumococcic Lobar Pneumonia.

Case No.	Age	Chronic Disease	Day of Pneumo.	Pn. Type	Site	B.C.	Treatment	Remarks
4	83	—	4	III	R.U., R.M., R. L., L. L.	—	Sulfapyr.	Advanced bilateral pneumonia. Died 7th day.
41	75	Severe bleeding peptic ulcer R.B.C. 2,- 190,000	2	III	R.U.	—	Sulfapyr.	Course unaffected. Died 7th day.
147	61	Advanced Paget's disease.	4	IV	R.L.	—	Sulfapyr.	Prompt recovery from pneumonia. Developed granulocytopenia on 22nd day. Died 25th day.
10	60	Advanced dermatomyositis	2	IV	R.L.	—	Serum and sulfapyr.	Pneumonia promptly controlled. Died from dermatomyositis.
70	81	Hypertensive cardiovascular. Azotemia.	1	VIII	R.L.	—	Serum and sulfapyr.	Immediate recovery from pneumonia. Died suddenly on 7th day. ? coronary thrombosis.
63	65	Bilateral pulmonary tuberculosis.	5	XIV	R.U., R.M., R.L., L.L.	+	Serum and sulfapyr.	Advanced bilateral pneumonia. Died 8th day.

age and only one death among the 17 bacteremic cases, of whom 9 were between forty and sixty-five years old. A more detailed analysis of the 6 fatal cases is shown in Table II.

Analysis of the data in Table II shows that 5 of the 6 fatal cases were individuals with severe chronic disease, 2 were advanced cases with extensive bilateral pneumonia, all were 60 years of age or more. One fatality (Case 147), however, may be attributed directly to sulfapyridine, since this patient developed agranulocytosis from which she died.

The incidence of empyema in the 87 cases who recovered was as follows: 1 case (Type I) had an infected pleural fluid when treatment with serum and sulfapyridine was started and developed purulent empyema; 2 cases (Type II and Type V respectively) had early empyema when admitted, the Type II case resolving without surgical drainage, the Type V case requiring thoracotomy; 2 cases (Type V and Type XIII respectively) developed empyema subsequent to

the institution of therapy. Both were drained surgically. Other infectious complications were thrombophlebitis in one instance, organizing pneumonitis with bronchiectasis or lung abscess in 3, in each instance probably due to a superimposed infection with staphylococci.

In addition to the 93 cases of pneumococcic lobar pneumonia 35 other cases of pneumonia were treated with sulfapyridine. These are summarized in Table III.

From Table III it may be seen that the one case of hemolytic streptococcic pneumonia responded well but that sulfapyridine apparently failed completely in staphylococcic pneumonia. The results in the 28 cases of bronchopneumonia are difficult to evaluate. In many instances these were undoubtedly mixed infections with virus (?), pneumococci of the higher types, H. influenza, etc. Five cases in children and four in adults recovered promptly by crisis, while 15 others who recovered were not obviously benefitted by sulfapyridine. The two bac-

TABLE III. Cases of Streptococcic, Staphylococcic and Bronchopneumonia.

Type of Pneumonia	Cases	B.C. +	Died	Remarks
Streptococcus hemolyticus	1	0	0	Severe with empyema which resolved under chemotherapy and drainage by thoracentesis.
Staphylococcus	6	3	4	One of two recovered cases developed lung abscess.
Bronchopneumonia:				
Infants	12	2	2	Pneumonia complicating acute upper respiratory infections. pertussis and measles. Results equivocal.
Adults	16	0	2	Results equivocal.

teremic cases in infants (Pn. Types XIX and XXIII respectively) both died. Of the two fatal cases in adults one was post-operative, one was a Pn. Type VI pneumonia occurring in a patient dying of chronic glomerulonephritis.

The usual prompt effect of sulfapyridine on the clinical course of pneumococcic lobar pneumonia is illustrated in Chart 1. Of the 60 cases treated with sulfapyridine alone 42 showed a similar critical recovery with fall of temperature to normal within 24 hours and remained well except for certain untoward reactions due to the drug to be mentioned below. Of these, 6 were treated on the first day of the disease, 12 on the second and 11 on the third, early enough, therefore, to justify the opinion that the prompt recovery was due to the bacteriostatic action of sulfapyridine. Nine more of the 60 cases recovered by rapid lysis within 48 hours and remained well. Five patients had a temporary recurrence of fever subsequent to the initial fall of temperature to normal. These were interpreted as infectious relapses, though it is possible that some of them may really have been drug fever, since the differentiation between the two may at times be difficult to make.

Some of the problems involved in the use of sulfapyridine in lobar pneumonia are concerned with dosage, desirable duration of treatment after fall of temperature to normal, the blood concentration necessary for effective therapy and the factors influencing it, the variable and unpredictable degree to which free sulfapyridine is converted to the acetyl derivative and its possible significance, the frequency of nausea and vomiting, methods of parenteral administration, the occurrence of untoward reactions, and finally the perplexing question of choice among serum therapy, sulfapyridine therapy and combined therapy in the individual patient. Doubtless only longer experience will serve to solve many of these questions definitively, though tentative answers to some are beginning to emerge.

### Dosage

In general in adults we have found as others have, that an initial dose of 2.0 gms., or of 1.0 gm. q.h. for four doses, followed by 1.0 gm. q.4h. day and night for approximately 72 hrs., is satisfactory. If the temperature has fallen to normal and there have been no serious untoward reactions the dosage is then reduced to 0.5 gm.

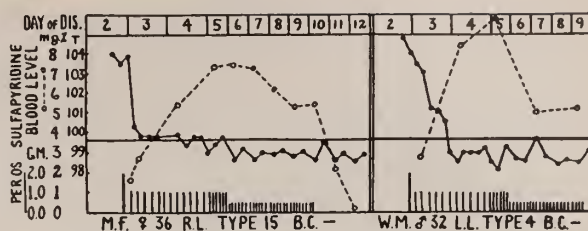


Chart 1. Critical cure of early pneumococcic lobar pneumonia with sulfapyridine.

q. 4 h. or 1.0 gm. q. 6 h. for two or three more days when the drug is discontinued. Appropriately smaller doses have been used in infants and children. In general 0.5-1.5 gms. for the initial dose, 0.25-0.5 gms. at four to six hour intervals for subsequent doses have proved effective.

### Duration of Treatment

How long it is necessary to continue treatment after the temperature has fallen to normal is debatable. Since it seems probable that the development of antibodies by the patient is necessary for permanent recovery, it may be that the duration of treatment should be related to the duration of the disease, being carried through the 7th to 9th days from onset rather than any definite number of days after treatment was begun.

Our own experience shows that of 36 patients in whom sulfapyridine was stopped on or before the 8th day of the disease, only 4 developed an apparent temporary relapse following discontinuance of the drug on the 4th, 6th, 7th and 8th days respectively. One other patient had a relapse, which occurred from the 5th to 8th days of her disease while she was still under treatment. Until further information is available concerning the frequency of relapse when treatment is stopped early, it would seem desirable to continue sulfapyridine at least through the 7th to 9th day after onset of the pneumonia, provided no untoward reaction occurs which demands immediate cessation of treatment.

### Blood Concentration

The dosage outlined above has served to establish promptly in the majority of our patients a blood concentration of free sulfapyridine ranging between 5 and 10 mgm. per 100 cc. as illustrated in Chart 2\*. In approximately 20

\*We are indebted to Miss Barbara Gallup for assistance in determining blood concentrations of sulfapyridine.



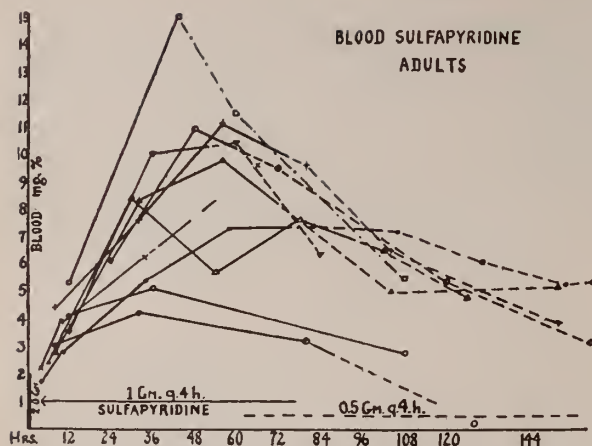


Chart 2. Free sulfapyridine concentrations in the blood in patients under treatment.

per cent, the concentration remained under 5 mgm. per cent, while in a similar number it rose above 10 mgm. per cent on the 2nd or 3rd day.

With any given dosage the two most obvious factors influencing blood concentration are variations in rate of absorption and rate of excretion of the drug.<sup>3</sup> High concentrations above 10 mgm. per cent were encountered more frequently in people over fifty years of age than in younger persons, presumably due to impaired renal excretion. When found they are an indication for reducing dosage or forcing fluids or both. Low concentrations may be due to inadequate absorption but are frequently due to another important and variable factor influencing the blood concentration of free sulfapyridine, namely the degree to which sulfapyridine is converted in the body to the acetyl derivative.<sup>4</sup> Consequently a low concentration should not be considered an indication for increasing dosage until it has been determined by measuring both total and free sulfapyridine whether or not a low or falling level of free sulfapyridine is due to a high or increasing degree of acetylation of the drug. If it is, increasing the dose may lead to acute hematuria and other untoward effects which will be discussed below.

When sulfapyridine was first used it was generally assumed that a blood concentration between 5 and 10 mgm. per cent would be the desirable one for satisfactory chemotherapeutic effect. Flippin and his collaborators,<sup>2</sup> however, were unable to show any consistent relation between blood level and therapeutic result. Our experience to date seems to confirm this ob-

servation. For example, in 32 early cases prompt critical recovery had occurred in 10 with blood concentrations of free sulfapyridine still under 5 mgm. per cent. On the other hand there were 3 of the remaining 22, all of whom had attained blood levels above 5 mgm. per cent, who were still febrile 24 hours after treatment was started. While it is apparent that some patients respond promptly and satisfactorily with relatively low blood concentrations, many more observations are necessary to establish how frequently this will occur. Consequently it would appear safer at present to adhere to the dosage outlined above, even though it may be somewhat more than necessary in some cases.

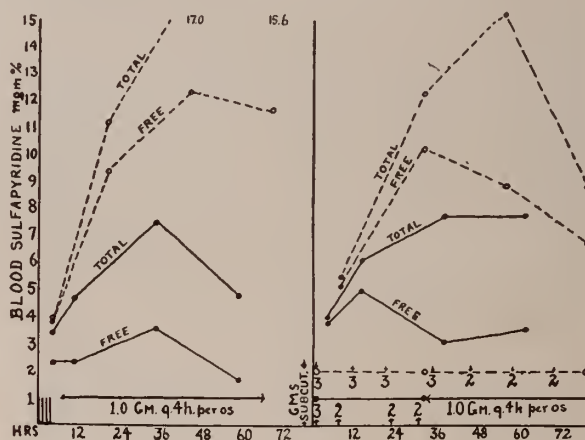


Chart 3. Variations in rate and degree of acetylation of sulfapyridine in four patients. Difference between total and free sulfapyridine represents the concentration of acetyl sulfapyridine.

### Acetylation

Sulfapyridine is in part converted by the liver to an acetyl derivative.<sup>4</sup> The rate and degree of conversion (Chart 3) appear to vary greatly from individual to individual and are unpredictable. Acetyl-sulfapyridine is highly insoluble and if present in high concentration in the blood may be precipitated in crystalline form in the renal tubules and pelvis<sup>5</sup> causing acute hematuria, which in its severer forms may be gross and accompanied by severe colic, suppression of urine and azotemia.<sup>6</sup> The percentage of sulfapyridine converted to the acetyl derivative may vary from 15 to 75 per cent. While there is insufficient data at present to establish a consistent relation between hema-

turia and the concentration of acetyl-sulfapyridine in the blood it already seems clear that a percentage rising above fifty with an acetyl-sulfapyridine level of 3.0 mgm. per cent or more is a warning signal. Consequently it would seem a desirable precaution to determine both total and free sulfapyridine at least from the second to fourth days of treatment, the acetyl derivative being the difference between the total and free sulfapyridine. As pointed out above, an unexplained fall in free sulfapyridine level after the second day of treatment, provided dosage has not been reduced, is usually a sign of increasing acetylation and should be an indication for promptly determining the acetyl-sulfapyridine concentration. If the danger zone is present fluids should be forced, the urine should be examined for red blood cells, and sulfapyridine promptly stopped if hematuria appears.

### Nausea and Vomiting

The most frequent problem encountered in the use of sulfapyridine is nausea and vomiting. This would appear to be a central toxic effect since it occurs not only when the drug is given by mouth but also with parenteral administration. In our experience it has occurred to some extent in approximately 60 per cent of patients, being quite severe in a third of these. It usually begins within a few hours after the initial dose and lasts for two to four days, after which it ordinarily abates, even though sulfapyridine be continued. In the more severe cases patients become unable to take fluids or nourishment and adequate dosage of sulfapyridine becomes difficult or impossible to maintain. Under these circumstances we have resorted to parental administration using a 0.13 per cent solution in normal saline or a 0.20 per cent solution in 5 per cent glucose solution or in equal parts of normal saline and 5 per cent glucose solution.† These solutions may

be given by hypodermoclysis or intravenously without any local or general reactions. In general two infusions or clyses daily, containing 2.0 gms. each of sulfapyridine and given at twelve hour intervals, have been found adequate for the maintenance of proper blood levels and satisfactory therapeutic effect.

If for any reason it seems necessary or desirable to begin sulfapyridine treatment parenterally, an initial intravenous treatment of 2.0 gms. in 1000 cc. of 5 per cent glucose solution followed by a hypodermoclysis of 2.0 gms. in 1500 cc. of normal saline will promptly establish an adequate concentration of sulfapyridine in the blood and maintain it for approximately twelve hours.

While parenteral administration may not immediately check nausea and vomiting because of the central action of sulfapyridine, the procedure outlined above possesses, in our opinion several advantages over the use of sodium sulfapyridine described by Marshall and Long<sup>7</sup>, in that the drug may be given either subcutaneously or intravenously, there is no danger of local tissue injury and the method provides salt, glucose, and water for patients who are much in need of them because of high fever, persistent vomiting and inadequate intake. Further more detailed data concerning this method of treatment will be published elsewhere.

### Untoward Reactions

The immediate untoward reactions associated with sulfapyridine therapy are in general similar to those due to sulfanilamide. During the first few days patients are frequently depressed or irritable. Nausea and vomiting, much more frequent and severe than with sulfanilamide, have already been referred to. While some cyanosis is frequent, it is in our experience less noticeable than with sulfanilamide. We have not seen any cases of clinically recognizable acidosis.

The delayed reactions also appear to be similar to those encountered with sulfanilamide therapy<sup>8</sup>, namely drug fever, dermatitis, acute hemolytic anemia, and granulocytopenia.<sup>9</sup> The frequency of these reactions in the series of cases reported here is summarized below.

Drug fever with a more or less extensive, morbilliform, maculopapular rash (Chart 4) occurred in 9 of 95 cases or approximately 10

†In preparing these solutions 1500 cc. of normal saline for the 0.13 per cent solution, 1000 cc. of 5 per cent glucose solution or 500 cc. of normal saline plus 500 cc. of 5 per cent glucose solution for the 0.20 per cent solutions, are brought to a boil. Without further heating 2.0 gms. of pure powdered sulfapyridine are added, the mixture is stirred with a sterile glass rod until the sulfapyridine is dissolved, and the solution is then allowed to cool off to body temperature before administration. Solutions may be maintained at room temperature for several hours at least but should not be stored in the ice-box. It should be noted that 2.0 gms. will not stay in solution in 1000 cc. of normal saline alone.



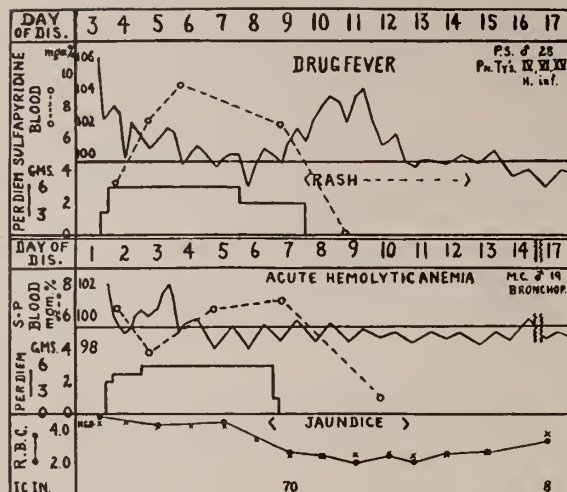


Chart 4. Cases illustrating drug fever and acute hemolytic anemia.

per cent (33 cases receiving antipneumococcus serum excluded because of possible confusion with serum disease). The occurrence of drug fever bore no determinable relation to age of patient, dosage, duration of treatment or type of pneumonia. The clinical picture was comparable in all respects to the familiar picture of drug fever occurring with sulfanilamide therapy<sup>10</sup> and consequently need not be elaborated upon here. Treatment consists in stopping sulfapyridine if it is still being given. The major point requiring emphasis is that an unexpected rise in temperature five or more days after the beginning of sulfapyridine treatment should not be regarded as an indication for increasing or resuming sulfapyridine therapy until the possibility of drug fever is excluded.

Acute hemolytic anemia, with jaundice and a rapid fall in red blood cell count and hemoglobin from normal to 2,010,000 R. B. C. per cu. mm. and 48 per cent Hgb., occurred in one instance (Chart 4). The onset was on the fifth day of treatment. Following discontinuance of sulfapyridine the jaundice cleared in five days and the blood count gradually returned to normal. Transfusions should be used in severe cases. In addition to this acute form of hemolytic anemia many patients developed a moderate anemia during treatment, insufficient in degree, to cause any special concern.

Granulocytopenia occurred in four cases. In three of these in infants it did not progress to a complete agranulocytosis and the total and

differential white blood cell counts returned promptly to normal following immediate discontinuance of sulfapyridine. In the fourth case (Table II, Case 147) granulocytopenia developed on the 22nd day, the total W. B. C. dropped rapidly to 450 per cu. mm. with no granulocytes and the patient died.

Acute hematuria described above, occurred in 8 of the 128 cases in this series. It began on the third day of treatment in 4, on the fourth day in 2, on the sixth day in 1 and on the seventh day in 1. In four cases it was merely microscopic and cleared up after two or three days. In two instances it was more severe with smoky urine, moderate abdominal pain and costovertebral tenderness and low grade fever. The duration of symptoms was five days. In two cases the reaction was very severe with grossly bloody urine, severe colic, and fever. In one of these there was temporary suppression of urine and the blood nonprotein nitrogen rose to 86 mgm. per cent. With immediate stopping of sulfapyridine therapy and forced fluids all cases recovered. In five of the above eight cases in which the figures are available, the degree of acetylation on the morning of the third calendar day of treatment approximately 36-44 hours after sulfapyridine was started, was 44, 52, 58, 60 and 61 per cent, the actual blood concentration of acetyl-sulfapyridine 5.9, 3.1, 6.2, 4.7 and 7.3 mgm. per cent, respectively.

### Combined Antipneumococcus Serum and Sulfapyridine Therapy

We have used combined serum and sulfa-

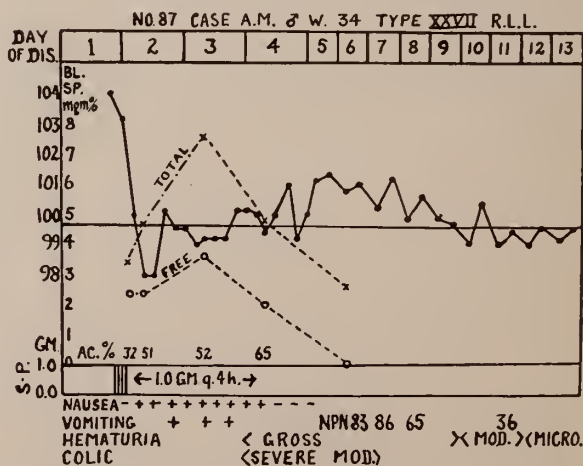


Chart 5. Case with severe hematuria. Note high degree of acetylation.

pyridine therapy in 33 cases of pneumococcal lobar pneumonia (Table I). Consequently our experience is far too limited to warrant the expression of any very definite opinion concerning the possible advantages of this procedure. Since in our experience either an adequate dose of serum or sulfapyridine alone is effective in causing prompt recovery in nearly all early cases of less than 60 hours duration, it would seem quite unnecessary to submit persons in this group, if treated with serum, to the discomforts and hazards of sulfapyridine therapy or *vice versa*. In more advanced cases with extensive consolidation and possible bacteremia, immediate combined treatment would seem desirable. Further experience, however, may modify this opinion.

### Summary

Our still somewhat limited experience with sulfapyridine in pneumonia may be summarized as follows:

1. Sulfapyridine appears to be a highly effective chemotherapeutic agent in pneumococcal lobar pneumonia. In spite of its curative value a considerable number of deaths may be expected in persons over sixty years of age, particularly in those subject to chronic disease.

2. Sulfapyridine is probably as effective in hemolytic streptococcal pneumonia as sulfanilamide but unless it can be shown that it is more effective, sulfanilamide should be preferred because of the less severe reactions associated with its use.

3. No evidence has been obtained that sulfapyridine is of significant value in severe staphylococcal pneumonia but further observations are necessary before it can be definitely concluded that it is of no value.

4. No evidence has been obtained that sulfapyridine is therapeutically effective in the so-called "atypical" or bronchopneumonias, not predominantly of pneumococcal etiology.

5. In view of the foregoing observations and because of the discomforts and hazards associated with sulfapyridine therapy, etiological diagnosis of pneumonia is essential for the proper selective use of sulfapyridine and the evaluation of its effectiveness.

6. Our observations do not permit as yet, a precise statement concerning dosage, desirable duration of treatment, the relation of blood concentration to therapeutic effectiveness and the

clinical significance of acetylation. The suggestions set forth in the text concerning these problems seem reasonable at present but may require modification after more extended experience.

7. The most frequent and distressing early toxic effect of sulfapyridine is nausea and vomiting, which occurs in fully half of the patients treated. Fortunately, this abates spontaneously after two or three days in most cases. When nausea and vomiting are severe, parenteral administration of sulfapyridine in normal saline and glucose solution according to the method described may profitably be substituted for oral administration until nausea and vomiting have ceased.

8. Later untoward reactions encountered are drug fever with maculopapular rash, acute hemolytic anemia, granulocytopenia, and hematuria, which may be gross and accompanied by severe colic, suppression of urine, azotemia and fever. Because of these reactions patients being treated with sulfapyridine should be closely observed, blood counts and urinalysis should be done daily, and when possible the concentration of free and acetyl-sulfapyridine in the blood should be determined at least during the first three or four days of treatment and at intervals thereafter if treatment is prolonged. With the onset of any of these untoward reactions sulfapyridine should be stopped immediately, fluids should be forced and other appropriate measures employed as indicated.

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(Concluded on Page 705)



## Summing-Up Discussion of Papers By Drs. Wies, Chipman, Parmelee, Urquhart, and Blake\*

CHESTER S. KEEFER, M.D.,  
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Dr. Phillips, Members of the Society, Ladies and Gentlemen. I want to thank you for inviting me to be here on this occasion. It is indeed a pleasure to hear discussed in such an interesting manner highly fitting and varied subjects which include prevention and treatment.

Dr. Wies' paper on *Rational Therapy* was of great interest to all of us. It is a perplexing problem, however, and I think one should adopt only those drugs which have been confirmed to be effectual by experiment and which have been accepted by the Council on Pharmacy and Chemistry. In regard to prophylaxis of vaccines, I thought the subject was covered extremely well. I should like to stress, however, one or two subjects which seem to me very important. The question of small pox comes up in all prophylaxis. It is amazing to find how prevalent small pox really is. Only yesterday I found that two epidemics were going on in New York State. In both instances, infection was introduced into the communities by trailer camps. Secondly, it was amazing to the authorities how few people were effectively vaccinated and how many individuals were susceptible.

One very urgent problem is the control of respiratory infections. The problem is a recurrent one, and one inadequately met at the present time. Prophylaxis carried out now at the civilian camps is most encouraging. There is no adequate means of preventing the common cold, and while the evidence is conflicting, there are reports of vaccines which inhibit the growth of organisms in the nose and throat. Some workers assert that in the care of children complications have been reduced by vaccines. More studies of that sort must be carried out.

I was delighted to have the problem of the *x-ray fallacies* stressed as they were this morning.

The outside doctor sees so few cases of tumor that it is necessary for him to have consultation of the roentgenologist who sees so many. It is, therefore, necessary that there be close cooperation among the outside doctor, the roentgenologist and the clinician.

The treatment of those with tuberculosis has largely been taken over by the specialist. This has been ably outlined for us this morning. The common methods are pneumothorax or thoracoplasty.

It is always a great pleasure to hear Dr. Blake discuss *pneumonia*; for he is one of the outstanding students of this disease in this country and he has had so many years of experience behind him that one may take verbatim what he says. Our experience at Boston City Hospital shows that most of the patients with pneumonia are admitted to the wards where they are carefully followed. We are in complete agreement with what Dr. Blake had to say this morning, namely, that sulfapyridine is of value in the treatment of pneumonia. We have had no luck with sulfapyridine against staphylococcus, and found it no better than sulfanilamide against the streptococcus. As one studies the problem of pneumonia, two factors stand out as important in the prognosis of the disease, namely, (1) the age of the patient and (2) whether or not the patient has a bacteremia. Of course, there are other factors such as pregnancy which play an important part in the prognosis of the disease, but which are a much less frequent complication. Dr. Blake was one of the first people to point out that Type 3 pneumococcus is responsible for such a high mortality, largely because it attacks elderly people. I compared the statistics on pneumonia of three large clinics, each reporting approximately 1500 cases. The mortality rate in these clinics ranged from

\*Presented at the 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

15 to 48%, but when one compared the figures one found that the clinics having the highest mortality rate also had the highest percentage of old patients and highest percentage of cases with bacteremia. On the other hand, the clinics with the lowest mortality rate had the fewest old patients and fewest cases of bacteremia.

What we have done this year is to compare the results of our treatment in each of three ways: (1) using serum alone, (2) using sulfapyridine alone, (3) using both serum and sulfapyridine. With serum alone the mortality was 13%; with sulfapyridine 15%; with both sulfapyridine and serum 22%. Analysis was very hazardous, for one can show that really our best results were obtained with treatment combining serum and sulfapyridine. In the group of cases so treated, all the patients were over 60 years of age and there was an incidence of bacteremia in over 60%.

From previous experiences, we knew that our fatality rate in such a group of cases was over 60 per cent. Therefore, the results which we obtained from the combined use of serum and sulfapyridine in this group of patients surpassed anything that we had been able to accomplish in the past.

When sulfapyridine alone was used, the best results were observed in patients under 40 years without bacteremia. At present, it is routine for the patient who is admitted with pneumonia to have his sputa typed and his blood cultured. Sulfapyridine is started at once. If the patient has bacteremia, we use serum in addition to the sulfapyridine. When the patient is over 50 years of age, we usually use both sulfapyridine and serum whether bacteremia is present or not. We have also treated pregnant women with both methods because we know that the mortality rate is twice that of non-pregnant women at the same age period. So, we can confirm everything Dr. Blake has said.

Some of the difficulties in the use of this drug have already been pointed out. Nausea and

vomiting are two of the hardest conditions to treat. Hematuria along with anuria or oliguria and nitrogen retention is a severe complication. If the urine is concentrated one is more likely to see renal colic, anuria, hematuria and renal insufficiency. In one of our cases examined at autopsy we found the kidney tubules filled with the acetylated form of sulfapyridine.

—☆☆—

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(SEE PAGE 2.)



# Horace Wells Conquers Pain.

## A 95th Anniversary Review.

By MAX E. SOIFER, D.D.S.\*  
Hartford, Conn.

Two attempts<sup>1 2</sup> have been made recently to malign and discredit the established reputation of Doctor Horace Wells, Dentist of Hartford, Connecticut as the discoverer of anesthesia. These garbled half-truths and historical inaccuracies were answered by earlier writers<sup>3 4 5 6 7 8</sup> and again refuted in current periodical literature.<sup>9 10 11 12 13 14 15 16 17</sup> On the occasion of the 95th anniversary of the discovery occurring December 11, 1939, it might be well to review briefly some highlights of the Wells story.

Horace Wells was born at Hartford, Windsor County, Vermont on Jan. 21, 1815. After a broad and liberal education in select schools, he started the study of dentistry at Boston, Massachusetts, in the offices of established practitioners as was the custom of the time before the inauguration of formal dental school training. For two years he prepared himself for his chosen profession and in 1836 finished his training and opened an office for a brief period in Boston. Later that year he moved to Hartford, Connecticut, where within a short period of time he firmly established himself as an outstanding and capable member of the profession. He published in 1838, an illuminating essay<sup>18</sup> which gained for him the respect and admiration of his professional confreres. Under his tutelage John M. Riggs and William T. G. Morton were given dental training during 1841-43. Both of these men later acquired fame in the profession. With Morton as a co-partner he opened another office in Boston to popularize one of his inventions for soldering teeth to dentures.

Witnessing an exhibition of "laughing gas" in Hartford given by Professor Gardiner Q. Colton on December 10, 1844, he visualized its application to dental and surgical operations

for the relief of pain and arranged for a demonstration at his own office the following morning. Here on December 11 Horace Wells underwent the first extraction of a tooth under nitrous oxide gas thus giving to suffering humanity the boon which had long been sought. On this memorable day, ninety five years ago, anesthesia, was conceived, demonstrated and proclaimed by Wells. Together with Riggs he experimented both with nitrous oxide and ether, but on the advice of his associates he preferred the former as more suitable for short dental operations. The following month he visited Boston in order to lay his findings before the Medical Faculty there and to make his discovery "as free as the air we breathe." Unfortunately, due to his excitement at having to perform the dual role of anethetist and extractor, his demonstration was only partially successful and his patient did cry out, yet admitted afterwards that he felt no pain. Few of those present on this occasion really understood the manifestations of patients in this anesthetized state and therefore attempted to discredit Wells and his work. He returned, however, to Hartford and, except for brief periods during 1845 and 1846 when he was forced to relinquish his professional duties due to a physical ailment, Wells continued to administer the gas for dental and surgical operations up to the time of his death in 1848. He never, as has so often been claimed, abandoned either his profession or his favorite anesthetic.

Full recognition for his contribution came to his name from the Connecticut Legislature, the city, county and state medical and dental groups, the Medical Society of the State of New York, the Boston Gynecological Society, Parisian Medical Society, Spanish Odontological Society,

\*Librarian, Hartford Dental Society.

American Medical and American Dental Associations, medical and dental professions of England and the International Dental Federation<sup>13</sup><sup>15</sup>. Memorials have been preserved in Hartford, Chicago, Washington and Paris<sup>15</sup>. Countless tributes have been paid him in literature<sup>15</sup>. He remains, despite the assertions of other claimants, the recognized discoverer of anesthesia. This sentiment has been well expressed in a resolution received by his widow in 1873 from his professional confreres in England who declared: "The world is indebted to him not only for introduction of Nitrous Oxide as an Anesthetic but for having given that impetus to the study of Anesthesia which has resulted in the introduction of ether, chloroform and various other agents for affecting that object."

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#### EIGHTH CASE OF RARE DISEASE REPORTED

The fourth case of histoplasmosis, Darling's disease, to occur in the United States is reported by Frank J. Shaffer, M.D., John F. Shaul, M.D., and Reginald H. Mitchell, M.D., Washington, D.C., in *The Journal of the American Medical Association* for Aug. 5.

The disease is caused by a parasitic micro-organism. Only seven other cases have so far been reported in the medical literature; four of these occurred in the tropics and one each in California, Minnesota and Tennessee.

The present case was an American born girl of 11 months. She showed the typically enlarged spleen, kidneys and liver and anemia; parasitic micro-organisms were found at autopsy.

The Washington physicians state: "In spite of its apparent rarity, we believe that the disease may be more common in this country than is generally believed, and for this reason its clinical picture, pathology and possible epidemiologic aspects deserve the interest of the medical profession."

The authors have found only one suggestion as to its treatment, arsphenamine, which was reported in 1911 to have brought about complete and speedy cure.

They stress the advisability of considering this disease in the differential diagnosis of any obscure case of splenomegaly (enlarged spleen), especially if the splenomegaly is associated with intermittent fever, ill health and a decrease in the number of white blood cells.



# The Clinical Significance of Bleeding of the First Trimester of Pregnancy\*

FREDERICK C. LaBRECQUE, M.D.,  
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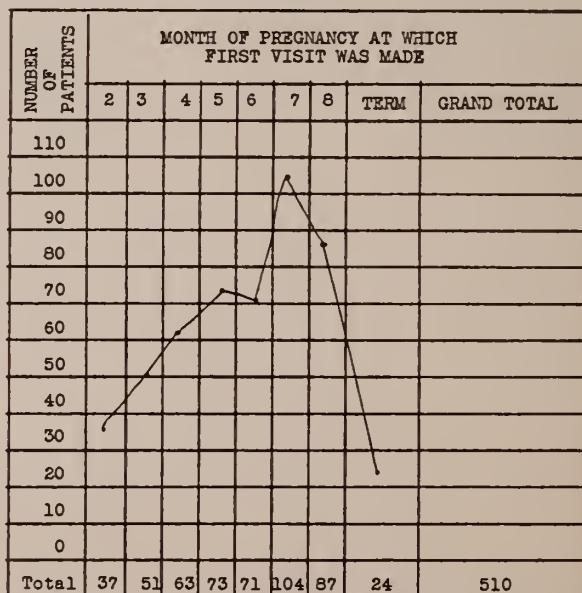
The importance of adequate prenatal care has been stressed repeatedly, not merely in the medical literature but also in the lay press, so that it is generally believed that patients consult their private physicians or visit the maternity clinics for the first time at a much earlier date in their pregnancy than did the patients of fifteen years ago, yet both private and clinic statistics definitely show that few patients see a physician for the first time during the first trimester of pregnancy. Examination of the records of 510 patients seen during the last six months in the prenatal clinic of the Massachusetts Memorial Hospitals reveals that only 17.2% or only 88 patients saw a physician for the first time during the first trimester of pregnancy. In other words, less than one out of every five patients who are pregnant consults a physician before the fourth month. Moreover, 42.1% or 215 patients did not see a doctor until the last trimester, the seventh month or later, and 4.7% or 24 patients were not seen by a physician until they were at term. (Chart I). It is evident, therefore, that despite the attention that is focused upon adequate prenatal care by the medical and lay press, patients today are still seeing their physicians or visiting the maternity clinics much too late in pregnancy and at least four out of five pregnant women pass through a most vital phase of their ante-natal period without any medical attention whatsoever.

When one considers that 37% of all women abort at least once before the age of thirty-one; that ectopic pregnancy occurs in one to one and one-half per cent of all pregnancies, and then adds to this the incidence of the various other causes of bleeding during the first trimester, it is clear that approximately 40% of all patients during the child-bearing age have, at one time

or another, bleeding as a complication during the first three months of pregnancy.

The reduction of the high incidence of this serious complication, bleeding, in the first trimester, can be brought about only by the combined efforts of the two parties concerned — first, the patient, and secondly, the physician. The patient should see her physician within two weeks of missing her menstrual period and the medical and lay press should present a solid front in the education of the public regarding the necessity of early prenatal examination. The second responsibility is the physician's — namely a clear conception of the causes and management of first trimester bleeding. It is the purpose of this paper to classify and discuss briefly the more common causes and essential management of bleeding at this time.

CHART I



\*From the Department of Obstetrics, Boston University Medical School and the Massachusetts Memorial Hospitals.

The bleeding of the first trimester of pregnancy may be classified as follows:

1. Pseudo-menstruation
2. Cervical:
  - (a) Cervicitis, Endocervicitis, Erosion
  - (b) Polyp
  - (c) Carcinoma
3. Intra-Uterine:
  - (a) Abortion
  - (b) Hydatidiform Mole
4. Extra-Uterine:
  - Ectopic pregnancy

Patients seen during the first trimester should be adequately examined and a pelvic examination which includes a speculum examination should be done. Then proper evaluation of the pregnancy may be made, factors that influence bleeding during the first trimester may be recognized and any abnormal findings may be investigated. A proper hygiene of pregnancy may then be outlined and the importance of bleeding strongly emphasized so that, should it occur, proper treatment may be started immediately.

Pseudo-menses is not uncommon. Patients at the time of their normal period may have a slight bloody discharge for a day or two, requiring the use of one or two pads each day. It is usually unaccompanied by cramps. The uterus at these times is definitely irritable and patients, unless carefully managed, are more likely to abort. This phenomenon takes place during the first trimester but usually ceases in the second trimester when the placenta becomes definitely formed. Such patients should be treated conservatively with absolute bed rest until the flowing has ceased, then examined carefully for the presence of definite pathology, after which they should be placed upon a careful regime, stressing particularly bed rest at the time when normally they would menstruate, avoidance of overexcitement, overexertion, long auto rides and coitus. Such patients should always see the physician as soon as a period is missed or is much less than normal, because with careful management pregnancy may not be lost. Anterior pituitary like substance or progestin may be given in an effort to augment the corpus luteum effect, and decrease the irritability of the uterus.

Fulkerson<sup>1</sup> found an incidence of cervicitis and endocervicitis in women to be 33.16% of which

92.3% were married. Of these latter, sterile marriages were found in only 19.9%. It is evident therefore that endocervicitis, cervicitis and erosion are common findings in pregnant women, particularly among multiparae. An annoying discharge is the most common and first complaint of these patients, but bleeding from such cervixes is not uncommon. These patients therefore complain of a painless, bloody discharge. The amount of actual bleeding is usually slight, the patients requiring but one and occasionally two pads daily. The diagnosis is easily made by pelvic examination, palpation and inspection of the cervix; but should there be any suspicion of malignancy, a Schiller test should be done, and a specimen taken for biopsy. Smears of the discharge should be routinely studied. The erosion should be treated with 50% Silver Nitrate and, if necessary, a simple electro-cauterization may be done. The indiscriminate use of the latter should be avoided and the conservative management carried out whenever possible. The bleeding will definitely cease and the erosion will gradually clear up with adequate treatment.

A very common cervical lesion causing bleeding during pregnancy is a polyp. It is readily felt and easily seen on speculum examination. Polyps may bleed slightly and at times, rather markedly, and the bleeding is not accompanied with pain. If it is not recognized, the polyp may gradually increase in size, the almost daily bleeding continue and a marked secondary anemia may develop. The treatment is simple excision, with the pedicle tied off or the base cauterized. The polyp should be sent to the laboratory for microscopic examination and although usually a benign growth, nevertheless, malignancy should be considered. Goldstein<sup>3</sup> recently reported a pedunculated adenocarcinoma of the cervix complicating pregnancy in a twenty-two-year-old girl.

Carcinoma of the cervix is a rare complication of pregnancy and too frequently unrecognized when present. The incidence of carcinoma of the cervix during the child-bearing period and particularly between the ages of thirty and forty is definitely on the increase, because both women and physicians are cancer conscious and the lesion is therefore being more readily diagnosed and at an earlier stage of the growth; but cervical carcinoma as a complication of pregnancy



seems to be rarely considered. Danforth<sup>2</sup> reports its occurrence as 0.0321%. The lesion is usually an early one. The symptomatology is that of painless bleeding, and on examination, the cancerous area of the cervix will be hard and nodular, in contradistinction to the rest of the cervix which is soft and patulous; on inspection, the hard nodular area bleeds to touch: it fails to take the Schiller stain and biopsy will show, usually, a rapidly growing squamous cell carcinoma. A characteristic of these lesions is that they grow much more rapidly during pregnancy than otherwise. Since these carcinomas are early growths, they should be recognized early in the pregnancy and with bleeding occurring frequently in the first trimester, we should, therefore, institute proper treatment as early as possible. Such treatment, not merely in the first trimester but up to the sixth month, consists of using radium and deep x-ray in full dosage.

Abortion is the most common cause of bleeding during the first trimester. Early prenatal care and proper management are the factors that will reduce its incidence. We exclude from this discussion induced abortions because obviously such patients do not want the pregnancy and therefore do not wish prenatal care.

Abortions may be classified briefly as follows:

(a) Threatened — when

- (1) The bleeding is slight to moderate with occasional clots.
- (2) The pains are cramp-like and fleeting.
- (3) The cervix is soft, no bleeding areas, the os is closed or not open more than  $1\frac{1}{2}$  fingers.
- (4) The uterus corresponds in size to the period of amenorrhea.

Every effort should be made to save the pregnancy and, therefore, conservative management is the proper treatment. Thus absolute bed rest, sedation, no enema or catharsis, no pituitrin or ergot; anterior pituitary like substance or progestin may be of some value in quieting the uterine contractions. The pains cease, then the bleeding ceases, and in one week they may be out of bed and placed upon careful regime.

(b) Inevitable — when

- (1) The bleeding is serious with many clots.
- (2) The pains are typical of labor pains.
- (3) The cervical os is open at least  $2\frac{1}{2}$  fingers. The membranes are ruptured

and the fetus protrudes.

(4) The uterus definitely contracts with each pain.

Since the pregnancy cannot be saved, the treatment consists in aiding nature with the expulsion of the fetus, and hence bed rest, enema, pituitrin lcc. every hour for three doses intramuscularly; and when the fetus is passed, ergot lcc. every four hours for six doses. Careful observation should be made to determine whether only the fetus or all the products of conception are passed. Blood should be typed and compatible donors obtained, in case transfusion should be necessary.

(c) Complete abortion — when

- (1) History of having passed all the products of conception is obtained.
- (2) Bleeding is slight.
- (3) Pains have ceased.
- (4) Cervical os is closed.
- (5) Uterus is involuting.

The treatment is conservative: bed rest, ice bag to fundus, catharsis, ergot lcc. every 4 hours for six doses. Patients are usually up and home in one week.

(d) Incomplete abortion — when

- (1) History of having passed only the fetus.
- (2) Bleeding continues moderate to severe.
- (3) Pains continue, cramp-like in character.
- (4) The cervical os is open and the tissue may be felt within.
- (5) The uterus is about the size expected for the period of amenorrhea or slightly smaller.

The treatment is conservative for twenty-four hours with four-hour observation of temperature, pulse and respirations; bed rest, enema, and pituitrin and ergot. Careful observation of tissue that may be passed — if temperature pulse and respiration are normal and tissue still remains within, then a dilatation and dull curettage should be done. Patients thus treated are usually up and home in one week. If the temperature pulse and respiration are elevated then conservative management should be continued indefinitely.

Hydatidiform Mole is essentially a marked proliferation of the Syncytium and Langhan's layer overlying the degenerated stroma of the chorionic villi. Its actual cause is unknown but characteristically it appears to be a formation of small or large irregular clusters or chains of

cysts. The vesicles are oval or globular in form, semi-translucent and pale yellow in color. Each vesicle is attached to the chorion by a short, delicate pedicle and contains a thin, clear fluid. In about 5% of the cases, malignant changes may occur, resulting in a chorion-epithelioma.

This condition should be seriously considered in every case of first trimester intra-uterine bleeding, and the small grape-like cysts should be looked for in the bloody discharge. These patients exhibit the typical signs and symptoms of early pregnancy. The bleeding is almost daily and painless, and a progressive secondary anemia results. One should suspect this when the following conditions are present:

- (a) daily, painless bleeding;
- (b) a soft, boggy, mushy uterus, definitely much larger than the period of pregnancy would suggest.
- (c) a cervix that is soft and does not account for the bleeding; the os is usually closed;
- (d) failure to ballot a fetus bi-manually; rather, the uterus is much enlarged and doughy;
- (e) a very strong positive Aschheim-Zondek Test;
- (f) a cystic mass in one vaginal vault.

The diagnosis may be finally confirmed by observing a grapelike cyst in the bloody discharge.

The treatment consists in typing the patient's blood and obtaining compatible donors and then emptying the uterus by either digital curettage or ovum forceps-removal, with free use of pituitrin 0.5 cc. in 2cc. of saline intravenously, and transfusion if necessary or abdominal hysterotomy. These patients should have follow-up Aschheim-Zondek Tests at one, two, three and six months and one year post-operatively. The tissue should be examined by competent pathologists for malignant changes and should the Aschheim-Zondek Test post-operatively be continuously positive, then the presence of chorion-epithelioma should be seriously considered.

Ectopic pregnancy is the implanter of the fertilized ovum outside the uterine cavity and may be classified as tubal, ovarian, peritoneal and abdominal. As the latter three are very rare, this discussion will limit itself to tubal pregnancy. Tubal pregnancy may be diagnosed before the severe rupture occurs, but when final

rupture does occur it is a most dramatic cause of first trimester bleeding.

Following the skipped period, at about the second week of the second month, there appears for about ten days to two weeks, a prodrome consisting of a dull aching pain with dark sero-sanguinous discharge. Such a patient, on pelvic examination, has a soft, patulous cervix with a closed external os, the uterus is about normal size and a small mass may be felt in the vault that is tender. The Aschheim-Zondek Test will be positive. The findings should be confirmed under gas-oxygen anesthesia and the patient then operated upon and the pathological tube and pregnancy removed.

However, since four out of five patients are not seen in the first trimester, then it is evident that most ectopic pregnancies are not seen until final rupture occurs. Such a patient presents the above prodrome, followed, usually at the end of the second month or early in the third month, by a severe attack of lower abdominal pain, frequently radiating to the shoulder or between the scapulae and occasionally toward one breast, associated with fainting and complete collapse. Temperature is subnormal, pulse weak, rapid and thready, blood pressure is very low, there is marked pallor, the skin is cold and clammy, there is exquisite tenderness over the entire lower abdomen, rarely there may be cyanosis of the umbilicus. The pelvic examination reveals a slight bloody discharge, a soft, patulous cervix with the os closed, the uterus is slightly enlarged but much smaller than one would expect for the period of amenorrhea. The cervix is exquisitely tender on motion and the posterior cul-de-sac is full, boggy and exquisitely tender. A mass is felt in one vault, exquisitely tender. The diagnosis is evident and Aschheim Zondek Test is unnecessary. Proper management consists in treating the shock — heaters, blankets, Trendelenberg position, fluids by hypodermoclysis, typing and obtaining compatible donors, morphia gr.  $\frac{1}{4}$ , and operating when donors are compatible. Intravenous fluids should be started with the skin incision, and blood transfusion started as soon as the bleeding is controlled with clamps. Patients usually improve rapidly and do well post-operatively.

Chart II summarizes briefly the highlights in differential diagnosis and treatment of first trimester bleeding.



CHART II.

	Cause	Pain	Bleeding	Cervix	Uterus	Vaults	Treatment
1.	Pseudo-menses	0	Slight	Normal	Size of 10 weeks	0	Rest in bed at time of menses. Avoid excitement, exertion, coitus, etc. Anterior Pituitary Like Substance — Progestin.
2.	Cervix						
A.	Erosion	0	Slight	Eroded	Size of 10 weeks	0	50% Agno <sub>3</sub> — Cautery if necessary.
B.	Polyp	0	Slight to moderate	Polyp palpable and seen with speculum.	Size of 10 weeks	0	Excision, cauterize base only if necessary.
C.	Carcinoma	0	Slight	Hard nodule, bleeds easily; rest of cervix patulous and soft.	Size of 10 weeks	0	Schiller Test — Positive Biposy. Radium — Deep X-ray.
3.	Uterus						
A.	Abortion						
1.	Threatened	Yes	Slight	Normal — Os closed or open less than 1½ fingers.	Size of 10 weeks	0	Conservative: Rest — No enema or catharsis; Sedation — Anterior Pituitary Like Substance — Progestin.
2.	Inevitable	Yes, like labor	Marked with clots	Normal—but os open 2½ fingers or more	Sz. of 10 wks. — membranes ruptured. Fetus in open os.	0	Bed rest — Sedation for pain. Pituitrin 1 cc. Every hour for three doses. Ergot 1 cc. Every four hours for six doses. Type and transfuse if necessary.
3.	Incomplete	Yes	Moderate to severe with clots	Normal — Os open; tissue felt within	Size of 10 weeks	0	24 hours observation and conservative treatment, as for inevitable. After 24 hours — if T.P.R. are normal, dull dilatation and curettage; if T.P.R. are elevated, continue conservative treatment.
4.	Complete	0	Slight	Normal — Os closed	Involutes	0	Rest — Ergot.
B.	Hydatidiform Mole	0	Slight to moderate daily	Normal — Os closed	Size of 14-15 weeks. Soft, doughy No ballotable fetus.	Ovarian Corpus Luteum Cyst in one vault.	Aschheim-Zondek Test — Strongly Positive. A. Digital Curettage; ovum forceps; intravenous pituitrin; transfuse if necessary; follow-up Aschheim-Zondek Test. B. Abdominal Hysterotomy.
4.	Ectopic	Dull ache	Sero-sanguinous discharge	Normal — Os closed	Size of 6 weeks	Tender mass in one vault	Aschheim-Zondek Test-positive — Salpingectomy.
	Before rupture						
	After rupture	Severe, radiates to shoulder	Slight	Normal — Os closed. Tender on motion	Size of 6 wks. Boggy - tender mass in posterior cul-de-sac.	Tender mass in one vault.	Treat shock; operate; transfuse.

The following are a few brief illustrative cases.

**1. Pregnancy — Chronic Endocervicitis — M. M. H. 265974.**

Mrs. M. H. — 29 yrs. old. P. o. G. II.

Seen for the first time 11-6-38.

C. C. — Bloody vaginal discharge of one week's duration.

L.M.P. Aug. 25 — No flow since; some staining following intercourse. Daily staining for one week, while up and around.

P. H. — Miscarriage — June 1938.

Abd. Exam. — Negative.

Vag. Exam. — Martial introitus, good perineum. Skene's and Bartholini's — negative. Cervix soft, external os closed. Uterus size of 2 months pregnancy. Vaults free. Speculum exam. — Cervix shows circular erosion that bleeds easily; soft, no evidence of malignancy.

Rx. AGNO<sub>3</sub> 50%—Smear—negative for Gonococcus.

Bleeding persisted — cervix then cauterized with electric cautery. No bleeding since. Patient delivered full term infant, May 1939.

**2. Pregnancy — Cervical Polyp — "Carcinoma in Situ" — Chronic Endocervicitis — M. M. H. — 267947.**

Mrs. C. H. — 33 yrs. old. L.M.P. Dec. 26 — Referred to Prenatal Clinic March 2 from Gyn. Clinic. P. IV. G.V.

Jan. 29 — Patient reported to Gyn. Clinic because of vaginal discharge, and slight blood streaking. Pelvic Exam. revealed parous introitus, fair support; cervix bilaterally lacerated; eroded and small polyp protruded from upper lip. Uterus appeared about normal size. Vaults free. Polyp was excised.

\*Pathological Report — Microscopic — "Section through the small bit of tissue purported to be from the cervix shows a structure more or less characteristic of a cervical polyp, a portion of which is intact. Along one margin, however, the epithelium becomes distinctly hyperplastic, heaped up, irregular and follows the glands down to their base. They show a slight degree of anaplasia and rare mitoses. There is no evidence of invasion. From the section at hand it is obvious that this tissue continues over onto the adjacent cervical mucosa and must be considered as 'Carcinoma in Situ.' The supporting stroma is edematous, the vessels are engaged, and there is moderate infiltration with chronic inflammatory cells."

The patient was seen by the Gyn. Clinic in three weeks, diagnosis of pregnancy was then made, plus diagnosis of "Carcinoma in Situ" of the cervix.

At prenatal Clinic patient was immediately examined, uterus was then the size of two months pregnancy and the cervix was bilaterally lacerated, soft, but in the upper lip there was a hard indurated raised nodule, definitely different to palpation from the rest of the cervix. It did not bleed to touch. The vaults were free, and patient was admitted to the obstetrical surgical service for treatment.

Despite the pathological report above, it was felt a second biopsy should be done, so on March 7, 1939 the biopsy was taken which included the entire hardened indurated area plus portions of normal feeling cervix of the anterior lip. The pathological report microscopically was:

"Section through the biopsy from the cervix shows the surface epithelium to be intact except at one margin, where it is broken away and has been replaced by a thin zone of granulation tissue. There is no evidence of malignancy. The underlying stroma is edematous and infiltrated with numerous plasma cells and lymphocytes." Dx. Chronic Endocervicitis showing erosion.

X-ray and radium therefore were not advised, and patient was discharged to prenatal clinic where she is seen every two weeks and at the present date, the cervix has healed well and there is no evidence of malignancy.

**3. Threatened Abortion — M. M. H. 246695.**

Mrs. D. S. — 21 yrs. old. P. III G. IV.

C. C. Vaginal bleeding, cramp-like lower abdominal pains, two days duration.

L.M.P. 3 months previously. Patient did not desire pregnancy and took Castor Oil and Quinine.

Abd. Exam. — Mass felt at brim of pelvis in mid-line.

Vag. Exam. — Parous introitus, fair perineum; cervix soft, os closed; uterus size of three months pregnancy; vaults free. Sl. bloody flow; no bleeding areas on cervix.

Rx. Absolute rest, sedation, no enemas or catharsis.

Symptoms quieted and patient delivered at term of living female infant.

**4. Threatened Abortion — Inevitable Abortion — Incomplete Abortion M.M.H. 265506.**

Mrs. V. E. — 21 yrs. old. P.o.G.I.

C. C. — Vaginal bleeding with cramp-like lower abdominal pains, six days duration.

L.M.P. June 19, 1938 — Seen for first time Oct. 9, 1938.

Patient had no flow until six days ago when she had slight cramps of lower abdomen associated with slight straining. Patient continued work around home until day before entry when she had rather marked lower abdominal pains associated with moderately severe vaginal bleeding, and clots. Used four napkins. No history of induction.

Abd. Exam. — Mass rises out of pelvis to just above symphysis.

Rectal Exam. — Cervix soft, ext. os closed. Uterus size of 3½ months.

Vag. Exam. — Slight vaginal bleeding.

Rx. Absolute rest, sedation, no catharsis or enemas.

Bleeding and cramps became more severe and on following day sterile vaginal examination revealed the membranous sac was in the vagina, which sac was removed; cervix was soft, the os dilated 2½ fingers, the uterus was definitely contracting. Dx. — Inevitable abortion.

Rx. Pituitrin (Obst.) 1 c.c. Stat & q. 1°2x. After fetus is passed, ergotrate gr. 1/320 q.4° 6x.

Fetus was passed with considerable tissue, Patient, however, continued to bleed moderately and complained of episodes of severe, cramp-like, lower abdominal pain. Vaginal Exam. revealed the cervix soft and os open 2 fingers tissue could be easily felt within.

Dx. — Incomplete abortion.

Rx. T.P.R. — normal. Dull dilatation and curettage was done and considerable placental tissue removed. Convalescence uneventful. Patient discharged on 5th P.O. day.



**5. Complete Abortion — M.M.H. — 263209.**

Mrs. H. R. — 29 yrs. old. P. o. G. I. L.M.P. Dec. 22.

C. C. — Severe cramp-like abdominal pains; severe bleeding; no history of induction.

On admission, vaginal exam. revealed fetus about size of 3½ months, placenta and membranes were in the vagina and these were manually removed. Pituitrin 1 c.c. and ergotrate gr. 1/320, were given.

Dx. — Complete abortion.

Convalescence uneventful and patient was discharged on 7th day.

**6. Hydatidiform Mole — M.M.H. — 250173.**

Mrs. S. T. — 37 yrs. old. P. II. G. IV.

C. C. — Slight vaginal bleeding, one month duration.

L.M.P. — March 3. No flow until May 4, then stained daily but never required more than one napkin. She was seen by L.M.D. who diagnosed pregnancy, threatened abortion. Despite treatment, flowing began the day before entry. No cramps. Hospitalization advised June 6.

Abd. Exam. — Mass rises out of pelvis in mid-line almost to umbilicus; non-tender, soft.

Vag. Exam. — Parous introitus, good perineum. Cervix soft, bi-laterally lacerated; os closed; cervix non-tender on motion. Uterus rises almost to umbilicus. Fetus not ballotable. Vaults clear. Slight bloody discharge.

June 8 — Despite conservative treatment, patient went into labor and passed large mass, size of cantaloupe, consisting of numerous small vesicles, gelatinous in appearance.

Patient typed for transfusion, then dull dilation and curettage was done. Pituitrin was given intravenously, bleeding was well controlled.

\*Microscopic Path. Report — "Tissue consists of mass of widely dilated chorionic villi which show considerable degree of necrosis, edema and hemorrhage. Large amounts of accompanying clotted blood are present as well as areas of acute inflammatory reaction. Relatively small sheets of decidua-like cells are present and occasional syncytial masses and giant cells. In several sections examined, however, there is nothing which could be construed as Chorion Epithelioma.

Convalescence uneventful. Follow up Aschheim-Zondek tests have been repeatedly negative.

**7. Ectopic Pregnancy — M.M.H. — 265494.**

Mrs. G. B. — 37 yrs. old. P.I. G. III.

C. C. — Severe lower abdominal pain, vaginal bleeding.

L.M.P. Aug. — no flow until 6 days before entry (10-8-38) when she had vaginal spotting associated with dull lower abdominal pain. This recurred two days ago. To-day she had severe lower abdominal pain associated with fainting and slight vaginal bleeding, followed later by vomiting.

P.H. Uterine suspension 1930.

Ruptured ectopic pregnancy 1937.

Has had one Ft. N.D.

P.E. T. 95.8°(m). P. 124 — weak, thready. R. 34. B/P-50/?

She showed marked pallor, skin cold, clammy.

Heart and lungs negative.

Abd. Exam. — Mid-line lower abd. scar. Entire lower abdomen spastic; no palpable mass. Hegar's Sign absent.

Vag. Exam. — Parous introitus; slight bloody discharge; cervix soft, exquisitely tender on motion; external os closed; uterus about normal size, somewhat softer in consistency; both vaults very tender with a questionable mass, very tender, felt on the left. Posterior Cul-de-Sac bulged with a boggy, exquisitely tender mass.

Dx. Ruptured ectopic pregnancy.

Rx. Shock — fluids, typing, morph. gr. ¼; operation, intravenous fluids, transfusion.

Convalescence uneventful and patient was discharged on 12th P. O. day.

**Conclusion**

(1) Four out of five patients pass through a most vital phase of their pregnancy, namely the first trimester, without any medical attention whatsoever.

(2) The medical and lay press must continue the important education of the public regarding early prenatal care — which means the reporting of the patient to his physician within two weeks of missing a menstrual period.

(3) The causes of first trimester bleeding are classified and discussed as to diagnosis and treatment.

(4) Carcinoma of the cervix does occur as a complication early in pregnancy, and must be seriously considered when the bleeding is cervical in origin.

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\*Pathology reports by Dr. Charles F. Branch.

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**REVEAL CHILD'S ADOPTION EARLY**

Adopted children should be informed of their adoption as early as they are able to understand it, *The Journal of the American Medical Association* advises.

"The common technic used," *The Journal* says, "is to tell them that whereas most of their friends had to be accepted, their foster parents picked them out and chose them from a group of children and liked them best. That usually pleases the child and helps break the ice."

# The JOURNAL of The Connecticut State Medical Society

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**MANUSCRIPTS.**— Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

**ILLUSTRATIONS** — Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

**NEWS.**— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

**ADVERTISEMENTS.**— All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

**SUBSCRIPTIONS.**— Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

**REPRINTS.**— Reprints of papers and obituaries may be obtained from the Editor at cost.

## • Editorials •

### THE PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

During the "five persecution years" (1934-1939) the American Medical Association was criticized even by some of its members for being reactionary, obstructive and antiquated. Social changes are taking place within our nation. Much thought has been given to the wisdom of proposed national health legislation. Factual data has been afforded widespread publicity by the government to show that this nation is in dire need of an improvement in medical care. A recent survey by the American Medical Association has served to disprove much of this data. Health legislation has been proposed which if enacted will place the medical profession entirely under the supervision of governmental bureaucracies, destroy the relationship now existing between patient and physician, and add greatly to the tax payer's burden.

The House of Delegates, recognizing the implications of this proposed legislation and the vastness of the problem, has refused to be stampeded. Facts are now at hand to show that there is a need for developing plans for better distribution of medical care, that the medical care of the indigent should be improved, and that diversified conditions throughout the nation require different plans for the different areas. Never before however, has our national health been as good as it is today.

The American Medical Association now presents a platform (see page 688, this issue) which is designed to be applicable to every section of the United States and to all groups. It is not opposing anything but is asking the government to proceed with it in planning better distribution of medical care. At the Conference of the National Health Program held in Washington in 1938, the cards were all stacked against the medical profession. This certain members of Congress have admitted. Now the government has agreed to sit down in conference with organized medicine before proposing any further health legislation. Will they do this? We shall see.



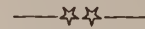
### HERBERT SPENCER IN 1940

"These various influences working from above downwards meet with an increasing response of expectations and solicitations proceeding from below upwards. The hard-worked and overburdened who form the great majority, and still more the incapables perpetually helped who are ever led to look for more help, are ready supporters of schemes which promise them this or the other benefit by state-agency, and ready believers of those who tell them that such benefits can be given, and ought to be given. They listen with eager faith to all builders of political air-castles from Oxford graduates down to Irish irreconcilables; and every additional tax-supported appliance for their welfare raises hopes of further ones. Indeed the more numerous public instrumentalities become, the more is there generated in citizens the notion that everything is to be done for them, and nothing by them. Each generation is made less familiar with the attainment of desired ends by individual actions or private combinations, and more familiar with the attainment of them by governmental agencies; until, eventually, governmental agencies come to be thought of as the only available agencies."\*

Written by the English philosopher, Herbert Spencer, in 1884, how well this fits the picture in the America of the mid-twentieth century! Spencer, an individualist of an extreme laissez-faire type, here shakes off the political cloak so frequently surrounding him and calls forth the individual from his complacent comfort in a society supported more and more by governmental agencies. Here we have the germ plasm for England's dole system. Political aircastles abound in our nation today; public instrumentalities, better known as bureaucracies, are becoming more numerous to day and each generation is indeed made less familiar with the attainment of desired ends by individual actions or private combinations. State medicine, health insurance, federal control of the selection of one's physician, all dwell in these political aircastles of the present day. Bureaucracies, eager to engulf the individual practitioner, lurk around the corner. The rugged individualism of the family doctor must give way to the mechanized dis-

\*From Herbert Spencer, "Man Versus the State", quoted from Nation's Business for August, 1934.

pensing by governmental agencies if we submit to such schemes as are proposed in the Wagner bill and similar ones now under consideration by our government.



### HORACE WELLS AND THE ANESTHESIA CONTROVERSY

On December 11, the date of the discovery of anesthesia in Hartford, Connecticut, we pay tribute to Horace Wells. No one reading the historical evidence substantiating Doctor Wells' claim as the discoverer of anesthesia can take issue with the facts. He was the patient and to him was successfully administered nitrous oxide while a tooth was extracted. Crawford W. Long had not published any of his experimental work with anesthetics. The use of ether at the Massachusetts General Hospital in Boston by Thomas Green Morton came at a later date. The Connecticut Legislature accorded Horace Wells, dentist, the honor due him. Local medical and dental groups recognized his claim, State and national medical and dental organizations, as well as foreign medical and dental organizations, afforded him full recognition.

The resolution received from England by his widow is very expressive.

"The world is indebted to him not only for introduction of Nitrous Oxide as an Anesthetic but for having given that impetus to the study of Anesthesia which has resulted in the introduction of ether, chloroform and various other agents for affecting that object."



### THE GENERAL PRACTITIONER'S FORUM

In this issue of the Journal appears for the first time The General Practitioner's Forum. Designed for this particular group of our readers, it will contain bits of wisdom and factual data deemed important for the use of the family doctor. It is a pleasure to offer this column and to give this important but over worked group a section in the Journal designed for them alone. Inquiries concerning information found in the Forum are solicited. To T.P.R., M.D., one of our members, goes the entire credit for this addition to the Journal's usefulness. The more interest is evinced by inquiries received, the more will the author of the Forum feel repaid for his efforts.

## NATIONAL PHYSICIANS' COMMITTEE FOR THE EXTENSION OF MEDICAL SERVICE

The National Physicians' Committee for the Extension of Medical Service is a non-political non-profit organization for maintaining ethical and scientific standards and extending medical service to all the people, and cooperating with lay institutions and groups to make more generally known the achievements and to safeguard the independence of American Medicine.

To meet new needs which have arisen (1) steps must be taken to make available to the indigent and low income groups the most effective medicine, medical practice and hospitalization that can be provided and generally — provide the widest possible distribution of the most effective methods and equipment in medicine and surgery; (2) if the public interest is to be best served it is essential that the general public be familiarized with the record and achievements of American Medicine. To meet these needs the National Physicians' Committee for the Extension of Medical Service came into being. On the central committee from Connecticut are the Secretary of the State Medical Society, Doctor Herbert Thoms of New Haven, and the Editor of the Journal.

This National Committee of Physicians is trying to do an educational job in reaching the people which the American Medical Association cannot do by virtue of income tax requirements involved with organizations engaged in lobbying.



## NORTH CAROLINA ENTERS THE LIST

The North Carolina State Medical Society has decided to publish an official journal of its own. T. W. M. Long, M.D., Roanoke Rapids, will be Secretary and Business Manager and Wingate M. Johnson, M.D., Winston-Salem is to be the Editor. North Carolina has made great strides during the past two decades. Our hearty congratulations to the State Medical Society in this new venture.



## SCIENTIFIC APPROACH NEEDED IN EVALUATING BIRTH CONTROL

Scientific study and reason should replace the hysteria and exaggeration which have accompanied the dissemination and formulation of

knowledge of birth control, George W. Kosmak, M.D., New York, contends in *The Journal of the American Medical Association* for Oct. 21.

"Full consideration of the historic, social, economic, legal and medical aspects," he believes, "is necessary to a proper understanding of this complex situation. For the control of conception is not a simple matter if we reflect on its wider implications, some of which are already becoming evident, among them the effect on our population balance. It is essential therefore that not only the medical profession but the public at large be thoroughly informed on the subject.

"Undoubtedly the medical profession has been hesitant to take an active part in a propaganda with which many of its members are out of sympathy, largely because of the hysteria and exaggeration which have accompanied its dissemination. However, the profession cannot refuse to recognize the firm conviction on the part of the public that procreation can, and perhaps should, be regulated.

"As physicians, we should constitute an active and influential force by which this effort can be guided in the proper direction. There is a sane as well as what may be termed an insane approach to a question which is agitating a great many people."

"While clarification of laws is needed, there was no evidence that existing laws interfered with a physician who felt called on to give information to patients. The committee expressed its opposition to independent and unlicensed birth control clinics and suggested the need of instruction to medical students in the entire subject of fertility.

"The committee recognized that voluntary limitation of conception may be necessary to safeguard the health of some women, as in the presence of active tuberculosis, heart disease, certain psychopathic conditions, chorea, or St. Vitus' dance, pernicious anemia, a recent serious illness or operation and a number of other conditions, especially in women physically incapable.

"The appropriate councils of the Association reaffirmed the committee's recommendation that contraceptive information should be limited to physicians in their private practice and to regularly licensed clinics under medical supervision.



# From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street

New Haven

## Hospital Plans and Medical Care

The Council at its regular monthly meeting in November discussed at some length the contract now in operation between the New Haven Hospital and the Plan for Hospital Care, Inc. Matthew Reynolds, Esq., of the Board of Directors of the Plan, and Mr. Robert Parnall, Manager of the Plan, were present at the invitation of the Council. The inclusive rate method of payment for services that has been instituted by the New Haven Hospital made necessary a change in the contract that had previously existed between the New Haven Hospital and the Plan for Hospital Care. Under this new contract some payment for medical services is made by the Plan for Hospital Care. It has been the opinion of the Council that this procedure was contrary to the principles expressed by the House of Delegates of The Connecticut State Medical Society at its Annual Meeting in May 1937 to the effect that "The Council recommends to the House of Delegates that the approval of The Connecticut State Medical Society be given to prepaid hospital service contracts only when such contracts exclude medical services of physicians other than those customarily rendered by a resident house staff, and, further, that The Connecticut State Medical Society will withhold its approval from such service plans that are not maintained on a non-profit making basis."

The subject will receive further consideration at a joint meeting of the Committee on Cooperation with the Yale School of Medicine and the Council.

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## Program for the Annual Meeting in 1940

The Program Committee consisting of A. Nowell Creadick, G. Gardiner Russell and Francis G. Blake, announces that the program for the 1940 meeting is rapidly developing. In an

effort to more closely integrate the Section activities with the general program the Committee invited the secretaries of all of the Sections of the Society to meet with it on October 31. This meeting was an interesting and productive one as it gave the opportunity to the Section secretaries who are most familiar with the personnel and wishes of their Sections to express their opinions concerning the organization of the program for the Annual Meeting.

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## Pneumonia Series

Announcement of the series of meetings to present the subject of therapeutics in pneumonia has been mailed to every physician in the State. This method of widely and promptly disseminating important clinical information has not before been tried in Connecticut. The results of it will be watched with interest and the Society is deeply appreciative of the cooperation that it received from the several local medical societies. The complete program will be found on page 687.

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## Specialist Advertising

From time to time the Council has been asked to consider the subject of specialist designation on physician's signs. The matter has again been referred to the Council and at its November meeting once more concluded that conduct in this regard was a matter of judgment on the part of the individual physician and should not be narrowly defined by regulations. And because customs vary in different localities it is the opinion of the Council that decisions concerning this matter should be left with the Board of Censors of the County Associations.

# THE CONNECTICUT STATE MEDICAL SOCIETY

and the

Connecticut State Department of Health

*announce a series of programs on the*

## TREATMENT OF PNEUMONIA

*to be given in co-operation with the  
following medical societies:*

BRIDGEPORT	NEW BRITAIN
CENTRAL	NEW LONDON
DANBURY	NEW HAVEN
GREENWICH	NORWALK
HARTFORD	NORWICH
MANCHESTER	TORRINGTON
MERIDEN	WATERBURY
	WILLIMANTIC

These societies extend  
to every physician in the State of Connecticut  
an invitation  
to attend any meeting in the series

**November 16, 1939 — 9:00 P.M.**

New Britain Medical Society  
Louis H. Nahum  
*Attending Physician Grace and St. Raphael's Hospitals,  
Assistant Attending Physician, New Haven Hospital  
Nurses' Home, New Britain Hospital*

**December 4, 1939 — 8:30 P.M.**

Hartford Medical Society  
Chester Kiefer  
*Associate Professor of Medicine, Harvard Medical  
School*  
Hunt Memorial Building

**December 6, 1939 — 8:30 P.M.**

New Haven Medical Association  
Russell L. Cecil  
*Professor of Clinical Medicine, Cornell Medical School*  
New Haven Medical Association Building

**December 7, 1939 — 8:30 P.M.**

New London, Norwich, Willimantic Medical Societies  
Francis G. Blake  
*Sterling Professor of Medicine, Yale Medical School,  
Physician-in-Chief, New Haven Hospital  
Uncas-On-Thames, Norwich*

**December 13, 1939 — 8:30 P.M.**

Danbury Medical Society  
Francis G. Blake  
*Sterling Professor of Medicine, Yale Medical School,  
Physician-in-Chief, New Haven Hospital  
Danbury Hospital*

**December 14, 1939 — 8:30 P.M.**

Waterbury Medical Society  
John A. Wentworth  
*Visiting Physician, Hartford Hospital  
Castle Memorial Building*

**December 19, 1939 — 8:30 P.M.**

Greenwich Medical Society  
Theodore S. Evans  
*Assistant Attending Physician, Grace Hospital  
Pickwick Arms Hotel*

**December 20, 1939 — 8:30 P.M.**

Central Medical Society  
Thomas P. Murdock  
*Director Medical Service, Meriden Hospital  
Bengston-Wood Hall, Middlesex Hospital*

**December 20, 1939 — 8:30 P.M.**

Norwalk Medical Society  
Francis Blake  
*Sterling Professor of Medicine, Yale Medical School,  
Physician-in-Chief, New Haven Hospital  
Norwalk Hospital*

**January 3, 1940 — 10:00 A.M.**

Meriden Medical Society  
Samuel J. Goldberg  
*Attending Physician, Grace Hospital  
Meriden Hospital*

**January 3, 1940 — 9:00 P.M.**

Torrington Medical Society  
Clarence L. Robbins  
*Assistant Attending Physician, New Haven Hospital  
Charlotte Hungerford Hospital*

**January 26, 1940 — 8:00 P.M.**

Manchester Medical Society  
Francis G. Blake  
*Sterling Professor of Medicine, Yale Medical School,  
Physician-in-Chief, New Haven Hospital  
Manchester Y.M.C.A.*

**March 5, 1940 — 8:30 P.M.**

Bridgeport Medical Society  
Speaker to be announced  
University Club

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## MID-WINTER DINNER

The Connecticut State Medical Society

Hartford Club, Hartford  
Seven o'clock

Thursday, January 25, 1940

Morris Fishbein, M.D., Editor  
*Journal, American Medical Association*

*"American Medicine and the National  
Government"*



## A.M.A. Annual Conference of Secretaries and Editors

### DR. BARKER HONORED

Doctor Creighton Barker, Secretary of our State Medical Society, was accorded the distinguished honor of being elected by a unanimous ballot to the position of Chairman of the Conference. It has been many years since our Society has received such recognition. The Conference is an annual gathering of the secretaries of the constituent State Medical Associations and the editors of their respective journals at the headquarters of the American Medical Association in Chicago. This year our Society was also represented, in addition to Doctor Barker, by the Editor of the Journal and by Doctor Frank S. Jones, a member of the Journal Editorial Board. At the Conference were many staff members of the various state associations and several members of journal boards in addition to the editors, bringing the total attendance to 400.



### PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

For the first time the American Medical Association has formulated a positive platform for which it stands in relation to the preventive program of medicine for the American people. It is as follows:

The American Medical Association advocates:

1. The establishment of an agency of federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.
2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.
3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.
4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

You will note that by this Platform the A.M.A. is not opposing anything but is asking the government to go ahead with it in planning better distribution of medical care.



### THE PLATFORM EXPLAINED

Item No. 1 of the Platform has been advocated by the A.M.A. since 1875 in the interest of efficiency, avoidance of duplication, and economy. Today the medical and health functions of the United States are divided among a multiplicity of departments, bureaus, and federal agencies. A member of the President's cabinet is not specifically requested as it may be found wiser to have a commission of five or seven members, all or part of which shall be physicians. The important thing is to have a central health agency.

Item No. 2 proposes that Congress make available such funds as can be made available for health purposes; that these funds be administered by the federal health agency (see Item No. 1 of Platform), and that the funds be allotted on proof of *actual need* to the federal health agency, when that need be for the prevention of disease, for the promotion of health, or for the care of the sick. Congress has not and cannot find the money proposed to be expended under the Wagner bill. The requirements for expenditures for the Army and Navy will soon push the national debt over the statutory 45

billion dollar limit. The need for expenditure of funds for medical care must be actual and must be proven.

Items No. 3, 4 and 5 are concerned with the local responsibility for medical care, the developments locally of a mechanism for meeting this responsibility, and the extension and local control of medical care to the indigent and the medically indigent. It is a known fact that federal agents have been active in selling to some states the demand for federal funds to be expended for medical care where the need for such funds did not exist. A fine business! The salesman from Washington creates the demand for an increase in your taxes!

Item No. 6 deals with the worst feature found in the Wagner health bill. Many hospitals have been built with federal funds where the need for them did not exist. Recently eight such hospitals were constructed in Michigan, the maintenance of which cannot be carried on without an additional tax upon the people. These eight hospitals are not properly equipped and are near excellent hospitals already in operation. Many so-called non profit voluntary hospitals in this country have not been occupied to anywhere near capacity in recent years. Available federal funds might better be utilized in providing the needy sick with hospitalization in these well established existing institutions before any attempt is made to indulge in a vast building program with new hospitals. In this point of view the American College of Surgeons, the American Hospital Association, the Catholic Hospital Association, the Protestant Hospital Association and practically every other interested voluntary body agree.

Item No. 7 reaffirms a belief in the private practice of medicine as opposed to salaried government doctors. The sickness and death rates of the United States are lower today than in any great country in the world. Better organization in the distribution of medical service and an improvement in the utilization of new methods for the distribution of costs might improve the situation. The medical profession has approved prepayment plans to cover the costs of hospitalization and also prepayment plans on a cash-indemnity basis for meeting the costs of medical care. It continues, however, to feel that the development of the private practice of medicine which has taken

place in this country has led to higher standards of medical practice and of medical service than are elsewhere available and that the maintenance of the quality of the service is fundamental in any health program.

Item No. 8 is so worded because of the conclusion reached after careful study of the history of the development of medical care in other nations, namely, that compulsory health insurance, state medicine and similar technics result in a trend toward communism or totalitarianism and away from democracy as the established form of government. The individual tends to become dependent on the state for food, clothing, shelter, and even for medical care and thus to become a creature of the state rather than the state being the servant of the citizen. (See editorial, "Herbert Spencer in 1940," page 684, this issue). Some of the plans offered for changing the nature of medical service strike at the very foundations of our democratic form of government.



#### RESULTS OF STUDY OF MEDICAL CARE IN UNITED STATES

Following resolutions passed in the 1937 House of Delegates and approved by the 1938 House of Delegates the American Medical Association conducted a study of medical care throughout the nation. This study pursued a different method from those previously used in that local situations were evaluated by the county medical associations. The study included dentists, nurses, hospitals, pharmacists, health departments, schools and colleges, relief organizations, and other units involved in medical care. Reports from 862 counties and 38 states were analyzed in this study. The most complete reports were made by the State Medical Societies of New Jersey, Delaware and Maryland. Pennsylvania made an excellent survey covering 51 of their 61 counties. The report shows that physicians contributed to free medical service about \$1,000,000 per day; also that about 16% of patients seen in home and office received treatment free, this being exclusive of the 20% who fail to pay for services and the group treated in hospitals.

Connecticut did not engage in this survey as suggested by the A. M. A. but has in operation a unique plan of study whereby a commission



appointed by the Governor and financed by the State is now functioning and will report to the 1941 General Assembly. This Commission is under the able chairmanship of our State Society Secretary, Doctor Barker.

Certain conclusions have already been reached by the A. M. A. Study. First that the problem of medical care of the indigent transient is not being properly met. Second, that there is a need for developing plans for better distribution of medical care. Third, that diversified conditions require different plans for different areas of the United States.



### FEATURES OF WAGNER HEALTH BILL

Doctor W. C. Woodward, Director of the Bureau of Legal Medicine and Legislation of the American Medical Association, called attention to the Wagner bill, its undesirable features and new legislation pending.

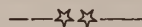
The estimated annual cost to the people of the United States as proposed in the first three recommendations of the Wagner bill would be 850 million dollars annually within the ten year period.

The estimated cost of federal health insurance is \$2,600,000,000, assuming the population to be 130 million with services rendered at \$20 per person.

There has been a misunderstanding by the Senate subcommittee as to the proper handling of grants-in-aid to state agencies. There is nothing in the Wagner bill to limit the benefits intended for the poor or man of moderate means. These benefits are available to everyone from the wealthiest down. Certain recommendations are now being considered to establish financial income limits.

The Wagner bill is unsatisfactory to the Senate Sub-committee on Education and Labor which has had the duty of conducting hearings. *The Sub-committee will present a new bill during the coming session of Congress.* The A. M. A. has been promised that it will be called into conference before the new bill becomes an established fact but no such opportunity has yet been granted. Mr. Wagner no longer favors his own bill. *See your Congressmen before they return to Congress in January and inform them what proposed national health legislation should embody.* (If you do not know, read the A.M.A. Platform, page 688

this issue and communicate with Secretary Barker). A great change of sentiment concerning federal legislation in compulsory health insurance is taking place throughout the United States. Tremendous propaganda is still going on against the policies for which organized medicine stands. The fundamental values of medicine should be maintained. Order is coming out of chaos. This is no time for a defeatist attitude which many have assumed.



### ADDRESSES BY THE PRESIDENT AND PRESIDENT ELECT

Doctor Rock Sleyster, President of the American Medical Association, reviewed the functions of the central office at Chicago and emphasized the fact that the A. M. A. is our association. He paid fitting tribute to Doctor Woodward, Director of the Legal and Legislative Bureau, who will soon retire from active service.

Doctor Nathan B. Van Etten, President Elect, sounded a clarion call to renewed interest and renewed activity on behalf of the principles for which organized medicine stands. Better medical care will ensue but not by means of compulsory health insurance.



### SPECIFIC MEDICAL SERVICE PLANS

#### New Jersey Plan

The Medical Society of New Jersey reported on its plan for medical care. It had been advised by its counsel that the proposed plan was not insurance. The New Jersey Commission on Banking and Insurance advised the Society in August 1939 that the proposed plan was insurance.

To avoid the expense of litigation the plan is now undergoing developments necessary to place it under the jurisdiction of the Commissioner on Banking and Insurance. A skeleton fee schedule has been drawn up. Fees will be paid directly to the physician and will depend on the amount of money available and upon the fees usually paid for that type of work to that class of patients in that particular locality.

#### Michigan Medical Service

The Michigan State Medical Society developed an enabling act for non-profit group medical service, incorporated the plan with 35 directors, one-third of them physicians, and extended membership in the plan to employed

groups of twenty-five up to the age of sixty-five. Benefits include free choice of physician and medical care in hospitals but cost of hospitalization itself is not included. Services of nurses and dentists and drugs are not included.

The cost is \$2.00 per month for one individual. \$1.50 per month additional for inclusion of wife or husband, and \$1.00 per month additional for inclusion of dependent family. During the first year of membership only there is a registration fee of \$1.00. All legally registered physicians may participate in treatment of patients under the plan. A short fee schedule of fifty items has been established as a level for other fees. The costs are reduced by payment within thirty days. Members are limited to those with incomes of \$2,000 per year for individual subscribers and \$2500 for family subscribers. Arrangements have been made for specialist services, all on the same basis as the fees of the general practitioner. The plan is now in the hands of the Insurance Commissioner and will probably be approved for operation by January 1, 1940.

#### **Washington (State) Medical Service Bureaus**

Several plans are in operation in the State of Washington and some of them have been in operation for many years. These plans came into operation because of the wide prevalence of contract practice. The physicians are paid on a unit basis which is less than that of private practice fees. Rates charged vary from \$1.25 to \$2.50 per month in different localities.

#### **Medical Service Association of Pennsylvania**

To prepare for this plan Acts 398 and 399 were passed by the 1939 session of the Legislature. A tentative plan is now under consideration by the State Medical Society. Members of the Association elect directors, a majority of the members being physicians. There are to be at least nine directors and a majority of these must be physicians. The insurance department of the Association approves rates, fees, agreements, surplus, reserves, investments, and gen-

eral financial activities. The Health Department approves the physicians participating and the type of services rendered. An advisory council composed of prominent laymen selected by resolution at annual meeting of members fixes time of service, etc. There are district commissions, a board of review, an executive committee and officers of the Association. The subordinate officers are the only officials paid.



#### **A.M.A. DECIDES TO DROP "COL." AFTER COLORED PHYSICIANS' NAMES IN DIRECTORY**

The Board of Trustees of the American Medical Association at an official meeting recently held in Chicago decided to omit the designation "col." after the names of Negro physicians in the next edition of the American Medical Directory. The National Medical Association is now striving to gain the recognition of the colored medical societies so that their members may be qualified for membership in the parts of country where they are not admitted to the local societies.



#### **CLINICAL CONFERENCES ON OBSTETRICS AND GYNECOLOGY**

Clinical Conferences on Obstetrics and Gynecology are held monthly at the New Haven Hospital during the autumn and winter months. These Conferences have no relation to the postgraduate course in Obstetrics and Gynecology which was given in February of last year, the announcement in the November issue of The Journal to the contrary. These Conferences are designed chiefly for those whose primary interest is in the field of Obstetrics and Gynecology, while the postgraduate course is given for the general practitioners who wish to brush up on the subject.

The next Clinical Conference is planned for December 11 when it is expected that Doctor Douglas P. Murphy of the University of Pennsylvania will be present and discuss the subject of Fetal Deformities.

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## SECTION ON Orthopedic Surgery

**Poliomyelitis Transmitted to Rats.** The National Institute of Health reports, in an article written by Charles Armstrong, that a strain of poliomyelitis virus has been successfully transmitted to the eastern cotton rat. This transfer has been successfully carried out for eight generations. Once more this suggests the possibility of animal carrier in this very important question. Incidentally, it also suggests that rats can be substituted for monkeys as experimental animals in the studies of infantile paralysis. We thus have cows or cattle in general, monkeys, rats and swine in which the virus of poliomyelitis can be implanted successfully. Slowly the problem seems to be approaching some sort of a solution. (See Journal Vol. III, No. 11, pages 595 and 623).

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**Plight of British Orthopaedists.** A recent letter from London suggests great difficulties these days in getting on in the practice of medicine and orthopaedics in particular. The younger men are getting greater remuneration than they were before hostilities broke, while the older men cannot carry on with the limited pay all are receiving for full time with the government. It was suggested that a moratorium be declared on rents of offices during the emergency so it will not completely disrupt private practice.

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**Peter Heinrik Ling.** All Sweden this year celebrates the one hundredth anniversary of Ling who founded the Central Gymnastic Institute that set the Swedish people on the road to gymnastic supremacy of the world. Ling was not a physician but due to his great interest and teaching of gymnastics in health and disease, he was made an honorary member of the Swedish Medical Society. A visitor to Sweden is immediately impressed with the splendid physical development and excellent posture of the inhabitants of this most unusual country.

It was Ling who put the Swedish people in a frame of mind to accept universal gymnastic training in their high schools. From their in-

terests thus aroused, they have developed many gymnastic societies to maintain health or to regain health after disease. The nudist societies thrive in Sweden where there appears to be no false modesty. One can purchase openly on the news stand in all of the cities of Sweden weekly copies of a nudist magazine which is dedicated to the sun. Apparently, due to the limited number of months of the year when the sun shines in all its warmth, nudism has a host of followers. This respect for a healthy, upright, vigorous body is all to the credit of modern socialistic, monarchistic Sweden.

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**Professor Archibald Young, Glasgow, Scotland.** In Philadelphia, 1936, Professor Young read a distinctly interesting paper on the use of common hardware nails and screws in fixing fractures about the elbow. Those who heard him will long remember the humor that he displayed together with the highest ideals of surgery. As a general surgeon, he was particularly interested in the treatment of fractures. His loss to orthopedic surgery is great. A visit to his inspiring clinic made such a visitor come away with a fresh determination to carry on for the advancement of scientific surgery. He was an outstanding international surgeon whose death we all mourn.

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**Seventy-Fifth Anniversary Celebration,—Hospital for the Ruptured and Crippled.** Seventy-five years ago the Society for the Care of the Ruptured and Crippled was organized in the City of New York. This year the seventy-fifth anniversary of the founding of this society was celebrated at the Hospital for the Ruptured and Crippled with several days' program devoted to orthopedic surgery together with a sprinkling of general surgery. Interesting papers were read and individual members' work was demonstrated. Seven orthopedists from Connecticut attended a portion of these meetings, constituting quite a representative body.

The hospital is to be congratulated on the outstanding contributions it has made in its program to the highest bracket in our orthopedic training requirements during these years. Dr. Philip D. Wilson is the enthusiastic and inspiring leader and under his guidance the organization will go far.

-The-  
General Practitioner's  
Forum

This column is designed for the busy General Practitioner, with the hope that it will fill the need for concise, practical information, on the management and treatment of the various common ailments encountered daily. Current literature, recent textbooks and contacts in the larger clinics will supply some of the material; but it is hoped that much of the material will come from the General Practitioners themselves. All have a pet method of doing the thousand and one things that come up in everyday practice. The cutting of a cast, the removal of warts or the extraction of an overdue bill from an unwilling patient, all have individual touches. Why not pass them on?

Address all communications to the Editor, General Practitioner's Forum, Journal of the Connecticut State Medical Society, 54 Church St., Hartford.

Herpes Zoster (Shingles) painful and resistant to the usual forms of treatment, yields to Sodium Iodide intravenously. Usual dose, 2 grams (31 grains) every other day until four are given. For young or delicate patients half of the amount is sufficient. It acts like a specific.

Calcium in your prenatal cases has proven its value. Recent tests show that for best assimilation it should be given before breakfast in water or fruit juices, never in milk. Give it also to the nursing mother. It relieves those distressing symptoms of tingling, dizziness and weakness.

To smoke or not to smoke during pregnancy and lactation was the subject of an inquiry in a recent Journal of the A.M.A. The answer was no smoking. Reason given, nicotine absorbed and circulating in the mother's blood gets into the fetal circulation; and also that it is excreted in the mother's milk.

Alvarez of the Mayo Clinic reports that inhalation of 100 per cent oxygen may abort severe attacks of migraine. Usual dose, 6 to 8 liters per minute for at least an hour. Results are excellent. However, it revives an age old question. What is migraine? Is it a true disease entity or a psycho-neurosis, a hysterical conversion or a flight from reality? Who has any ideas?

T. P. R., M.D.

SECTION ON  
Proctology

The annual dues for the members of the proctologic section for the year 1939-40 are now due. All members who are registered are requested to remit to Doctor J. Grady Booe, 144 Golden Hill Street, Bridgeport. Any member of the society desiring to affiliate with this section may also communicate with Doctor Booe. An interesting program for the May meeting will be arranged.

The fall meeting of the New York Proctologic Society was held on November 9 at the Wickerham Hospital, New York City. After a business session the following interesting scientific program was presented:

1. Review of Literature on Pilonidal Cyst  
I. Kalow
2. Results from the use of Sulphanilamide in Ano-Rectal Disease.  
A. Opening remarks by A.W.M. Marino  
B. Case Reports —
  1. Chronic Purulent Colo-Proctitis with unusual complications. I. Skir
  2. Treatment of Gonorrheal Ano-Proctitis with Sulphanilamide R. Turell
  3. Sulphanilamide Therapy in Lymphopatheia A. M. Buda
- C. General Discussion.

The annual meeting of the American Proctologic Society will be held in Richmond, Virginia, immediately preceding the convention of the American Medical Association in June. The preliminary program will be published in this column as soon as it appears. As usual, a very interesting program will be assured to those attending.



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## Our Neighbors

### MASSACHUSETTS

The New England Society of Physical Medicine held a Clinical Conference at the Hotel Kenmore, Boston, November 8 and 9, with a special session at the Massachusetts Institute of Technology, November 10. The Conference consisted of clinical demonstrations and short talks on technique by some of the prominent practitioners in the field of physical medicine.

"At long last the Commonwealth of Massachusetts has taken measures for the protection of its citizens in medical affairs comparable to those other states," *The Journal of the American Medical Association* for Oct. 21 declares.

"For years the output of graduates of low grade medical schools unable to obtain licenses in any other state has flocked to Massachusetts. Two such schools not recognized in any other state have flourished almost under the shadow of the State House. In theory people were protected by the licensing examination; it is well known, however, that competence to practice medicine cannot be determined by a written examination alone. A written examination might as well be expected to test ability to paint a picture or to shoe a horse. The state has provided no machinery for a practical examination, which is the only kind of examination worth while in ascertaining fitness for medical practice.

"Now, however, by the Acts of April 30, 1936, and May 2, 1938, amending section two of chapter 112 of the General Laws, it has been decreed that no one may enter the licensing examination who is not a graduate of an 'approved' medical school. There has also been created an 'Approving Authority' which is to determine on request whether any medical school fulfills the requirements formulated and published by it. The way is now clear to enforce a standard for admission to the practice of medicine at least as high as the standards prevailing generally throughout the United States. After 1941 Massachusetts should cease to be the dumping ground of unqualified practitioners."

At the last session of the Massachusetts Legislature a bill was passed requiring that a blood

test for syphilis be taken at the first visit of all pregnant women to a physician. This law went into effect on November 1.



### NEW YORK

New York State chiropractors are planning an intensive campaign to break the "monopoly represented by the A.M.A." The drive will take the form of newspaper advertisements, radio broadcasts, mass meetings, and the formation of lay chiropractic "auxiliaries." Expenditures of \$50,000 to this end, a spokesman for the group said, were expected to be approved shortly by a special committee.

Mayor La Guardia, as he laid the cornerstone for the new 550 bed Triboro Hospital for Tuberculosis in Queens on September 28, 1939, expressed the hope that tuberculosis would be wiped out in New York by the time he is a grandfather. "This institution should be called the Hospital of Mistakes of the Past," the Mayor told the gathering at the ceremony. The building will be completed in the Spring of 1940 at a cost of \$3,500,000, with the Federal Government furnishing 45% of the cost.

Herbert C. Soule, M.D., Rochester, N.Y., suggests in an article on the stillbirth and neonatal death problem (N.Y. State Jour. Med., Oct, 15, 1939) that in each community a group of men interested in the problems of stillbirth and neonatal death should meet once or twice a year and discuss the progress in their community and their individual hospitals in reducing these death rates. These groups should include, if possible, obstetricians, pediatricians, pathologists, anesthesiologists and a health officer.

Under a law enacted at the last session of the New York State Legislature cancer is now a reportable disease. As soon as the new reporting forms are distributed all physicians will be held strictly accountable for failures to comply with the law.

The Alumni Association of the New York University College of Medicine announces the election of the following officers for 1939-1940: President, James W. Smith; Vice-President, L.B. MacKenzie; Secretary, Phineas Bernstein; Treasurer, Francis W. Sovak; Committee on Science and Education, Elaine Ralli, Samuel Standard, Norman H. Jolliffe.

The Nassau County Cancer Committee has



launched an educational campaign this fall. Profiting by the successes and mistakes of cancer programs in other states, the Nassau program is being developed in the way in which it can best serve the needs of the County. Educational materials are being prepared; cooperation is being secured from such important agencies as clubs, libraries, schools and churches; speakers are being furnished to large and small groups; and every effort is being made to make the program one of value and service to the community. Package labels and letters headed "Fight Cancer with Knowledge" are being mailed to a large list of Nassau County people. Doctor Louis C. Kress, Director of the newly constituted Division of Cancer Control of the New York State Health Department addressed a meeting of the Nassau County Medical Society on Cancer Night, October 31, at Garden City. An educational exhibit was on display before the meeting.

The Medical Society of the County of New York held a special meeting in October to consider a study of the problems of medical care. A self constituted committee of thirty four members of the Society has arranged two special meetings this season for the purpose of discussing medico-economic problems. It is the belief of this committee that the leading needs faced by organized medicine today are a more thorough prevention of preventable diseases, more efficient distribution of medical care and greater economic security for the physician. The county society must place its principal emphasis upon the relation of the physician to the community.

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#### NEW JERSEY

New Jersey now has a plan for the distribution of medical care among a selected low wage group of the citizens of that state. The Medical Service Plan of New Jersey was incorporated under the laws of that state on July 13, 1939. The incorporators are five members of the Medical Society of New Jersey, designated by the Board of Trustees of the Society. The corporation has adopted a Constitution and By-Laws. The Plan and the By-Laws have been presented to the Commissioner of Banking and Insurance for his criticism and suggestions. The Plan is not as yet actually established and in operation but should be as soon as all preliminaries are completed.

On November 24, 1825, the Legislature of New Jersey enacted a law authorizing the Medical Society of New Jersey to confer the degree of Doctor of Medicine. This degree was conferred but eleven times by the Society up to the year 1856. The Society is now contemplating an amendment to its charter whereby it would receive authority to grant the degree of Doctor of Civic Medicine as tangible recognition of outstanding services of its members.

The Medical Society of New Jersey has in effect a form of organization which is unique among medical societies and which has been the means of raising the efficiency of this Society. Each advisory committee adopts a program of objectives and actions and reports it to its sub-committee, which in turn reports it to the Welfare Committee. (One of the functions of this latter committee is to supervise the standards and extensions of private practice). Finally the Welfare Committee reports to the House of Delegates, or to the Board of Trustees, which assign a definite budget to each division and committee according to its projected program.

Amendments to the New Jersey Adoption Law became effective January 1, 1939. This law is of particular interest to the physician of this State because it very definitely affects him.

Neither the physician, nor any other individual may place a child for adoption without having the merits of the case investigated by order of the Court before the petition is heard.

The Court is required to order such an investigation; and may utilize the Department of Institutions and Agencies or an incorporated child-caring agency for this purpose. The Department may be appointed as "next friend" to give consent to the adoption when this has not been secured from the parent.

Good adoption practice requires that a child shall be at least six months old before being placed for adoption, and that the child should live in the new home at least twelve months as a test of adjustment before the adoption decree is granted.

Every precaution must be taken to assure that the child is sound in mind and body. The placement should be made, if possible, in a home of the same religious belief as that of his natural parents; and it should be a home in which there is good health, harmony and, sufficient means to provide for his welfare. The

## NEW JERSEY

racial heritage of the child and the adopting parents should be given consideration in making placement.

Never should pressure be exerted on the unmarried mother to give up her child. If it is her ultimate decision to give up the child, then the legal consent must be executed in order that all parties to a subsequent adoption may be protected.



## RHODE ISLAND

Rhode Island now enjoys the privileges of prepayment hospital service through the Rhode Island Hospital Service Corporation, known as the Blue Cross. The medical profession is represented on the Board of Directors and Executive Committee of the Service Corporation by the President of the Rhode Island Medical Society, Doctor Brackett.



## VERMONT

The University of Vermont College of Medicine, the sixth oldest institution of its kind in the United States, recently appointed as its dean, Doctor Hardy Alfred Kemp, from the faculty of Baylor University College of Medicine, Dallas, Texas. Several changes are being instituted in the instruction program of the school. Among the teaching practices being discontinued are those of preceptorship and undergraduate internships throughout the State. It has been found necessary to drop this work in order to consolidate the work of the students at the college. A month of obstetric training at the Wesson Maternity Hospital, Springfield, Massachusetts, and a month of urology at the Worcester City Hospital, Worcester, Massachusetts have been added to the curriculum. The clinical facilities of the DeGoesbriand Hospital, Burlington, and the Fanny Allen Hospital, Winooski Park, will also be utilized.

## - NEWS -

*from County Associations*

## Fairfield

On November seventh Doctor Clyde Alvin Clapp of Baltimore, Maryland, gave a delightful presentation of Ophthalmological Problems from the point of view of general medical or surgical practice. Doctor Clapp who is professor of Ophthalmology both at the University of Maryland and at Johns Hopkins, amply merited the high praise bestowed in the announcement of the meeting.

Doctor Thomas Francis, lately of the Rockefeller Hospital, and now professor of Bacteriology at New York University, presented the second of a series of papers on the general subject of Infection, on November fifteenth at Norwalk. In view of his recent work on Influenza, Doctor Francis was particularly qualified to speak on his phase of the subject: "So-called Contagious Diseases with Special Reference to Virus Diseases."

Congratulations to Doctors Wehger and Eddy on the arrival of the first-born. Rumor has it that the latter young man has already been presented with a football.



## Hartford

Doctors Ralph M. Tovell and Mario Garofalo of Hartford presented a paper on "An Evaluation of Intravenous Anesthesia" at the annual meeting of the Medical Society of the State of New York, held in Syracuse on April 27, 1939. This paper was published in the New York State Journal of Medicine, issue of November 1.

In the County Notes of the November issue, we expressed the satisfaction of Doctor James E. Murphy's many friends and colleagues in regard to his convalescence from a severe infection. Unfortunately, he suffered a relapse and it is our sad duty to record his death which occurred on

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Tuesday, October 31, 1939. His funeral, held at St. Lawrence's Church, was largely attended by both lay and professional friends.

Doctor I. S. Radvin, Harrison Professor of Surgery of the University of Pennsylvania School of Medicine, gave a talk on November 6, at the regular meeting of the Hartford Medical Society on "Some Recent Advances in the Treatment of Biliary Tract Disease." The presentation was very scholarly with the speaker referring frequently to many of those by whom the advances had been made, also to those who were the authors of theories and view-points some of which were substantially proven and therefore acceptable and some of which were on none too solid ground, unproven, and, therefore, unacceptable. Dr. Radvin stated at the outset that he wished to "debunk" several notions regarding the biliary tract. His "debunking" had to do prominently with first, liver function tests and secondly, the affects of various anesthetics on liver cells. He stated, claiming that it was quite well established, that for the most part liver function tests were not too reliable inasmuch as there exist a liver 80% of which is damaged and yet having normal protein utilization and 90% of damage with normal glycogen utilization retained. Regarding anesthetic agents, he stated that the vast majority of the biliary tract surgery in his clinic was done using spinal anesthesia. The inhalation anesthetics, with the possible exception of cyclopropane (and about this he said no proof had been yet deduced one way or the other), had various degrees of deleterious affects on the liver with ethylene being the worst offender of all in this respect. Spinal anesthetic agents might affect the liver because of anoxia resulting from an influence on blood flow through the liver but inhalation anesthetic agents affected the liver cells directly, besides acting upon the hepatic blood flow, producing hepatic anoxia. Doctor Radvin also spoke at length on the use of vitamin K in controlling the bleeding tendency in jaundiced patients. Many questions were propounded by various physicians present and ably answered by the speaker. It was an extremely interesting and valuable talk, comments of this nature being quite universal.

Congratulations to Doctor and Mrs. Walter L. Hogan of Hartford on the birth of John Eben.

Inquiries have been made as to whether or not meetings of the Surgical Section of the Hartford Medical Society are to be resumed. For some reason not generally known, there has not been a meeting of this Section for several months. These meetings have been missed by many for it had been felt that there existed a valuable place for them. It is hoped that they will be scheduled regularly in the very near future. If they are not to be resumed, it is the writer's opinion that, since the treasury is filled to almost overflowing, we make the obsequies auspicious and official by way of one last good meeting with a symposium on some surgical condition. As suggestions we offer "The Problem of the Bleeding Peptic Ulcer" or "Acute Appendicitis," (with deluxe refreshments to follow).

The semi-annual meeting of the Hartford County Medical Association was held at Shuttle Meadow Country Club in New Britain on October 24. There was a good attendance of members. Despite the rather chilly weather about 20 members played golf, and to about one-third of these prizes were given, those being so rewarded for their prowess at this ancient Scottish game (the origination by the Scotch of this popular pastime, despite almost universal belief, is disputed by the Irish) being Doctor George Dunne for low gross, Doctor Burwell Dodd, Doctor Orin Witter, Doctor Frank Simonton, Doctor James E. Stretch and Doctor Ralph E. Durkee. In the evening, approximately 115 members sat down and enjoyed a very splendid dinner. Doctor Albert F. R. Andresen, Clinical Professor of Medicine of The Long Island College of Medicine, Brooklyn, New York, was the guest speaker and his subject was "Interpretation of Gastro-Intestinal Symptoms." This was discussed by Doctor Robert F. Scholl of New Haven, Conn. Thirteen new members were admitted to the County organization at this meeting.

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### Litchfield

Lawrence Hopkins Reed, Corporator of the Charlotte Hungerford Hospital, died at his home in Litchfield on November 1. Charity to the poor characterized his life work. Especially were his efforts directed to the relief of misfortune among indigent hospital patients. A native of Maryland he was a patient at Saranac

Lake for a considerable length of time. While here he became greatly interested in those suffering from the "Great White Plague" and whether in Virginia, where he spent his winters, or in his adopted Litchfield Hills he was constantly in contact with hospitals. By his unremitting and unostentatious acts of kindness and generosity to the poor and needy will he be remembered.

The 22nd annual report of the Charlotte Hungerford Hospital has been published. In an excellent and exhaustive report to the Board of Governors' Dr. Albert Buck, Director of the Hospital, stated that 3,124 patients, the largest number in the history of the institution, had been admitted during the year ending June 30, 1939. Frederick L. Braman, President of the Board of Governors, pointed to the fact that the operating deficit for the past year was greater than the net income from invested funds; he suggested that the only recourse seemed to be a general increase in hospital rates. Reproduced from his report are the following interesting per diem costs for various services:

	<i>Costs</i>	<i>Rates</i>
Private .....	\$8.163....	\$6.00 to \$9.00
Semi-Private .....	\$5.386....	\$3.50
Compensation .....	\$5.138....	\$5.00
Ward .....	\$5.105....	\$2.50

For care in this institution the patient pays 63 cents in each dollar of the actual cost. Interest on endowment supplies 34 cents.

From the surgical department Dr. Floyd Weed reported that there had been performed a total of 2,386 operations with a mortality of 2.05%. Dr. Bradford Walker listed 585 admissions to the medical service. He stated that, although the incidence of pneumonia had remained unchanged the mortality had decreased from 21% to 16% during the past year.

On November 1, Dr. Charles S. Culotta of the Department of Pediatrics of Yale University School of Medicine gave an interesting and instructive talk on the "Recent Trends in the Treatment of Infectious Diseases of Childhood" before the Torrington Medical Society.

From the obstetrical department Dr. T. L. Thomson reported that there had been 543 admissions with 521 births. This represented an increase of 78, respectively, over the preceding high year. One maternal death occurred from hemorrhage. This patient had a placenta praevia and was admitted in extremis.

## Middlesex

During the past month members of the sophomore classes of both the Middletown High School and Woodrow Wilson High School have received tuberculin tests under the supervision of Doctor M. L. Palmieri. There were about 450 pupils tested, of whom it was expected twenty per cent would react positively. Those so reacting were to be taken to the Undercliffe Sanatorium in Meriden for an x-ray study of the chest. A similar campaign among the pupils of the junior classes was put on last spring. Those who reacted positively at that time and were x-rayed are to have a second x-ray study now.

Following a recent meeting of the Central Medical Society at which considerable opposition was voiced to the plan of the Board of Health having all laboratory work under its supervision done at the State Laboratory in Hartford, a committee of the Board of Health was appointed to study the matter. This committee consisted of Rev. Herbert D. Rollason, Doctors James Murphy, Louis Loffredo and Edgar Fauver. Pending a final report from this committee the Board has ruled that emergency examinations may be done at the local laboratory at the expense of the local Board of Health.

The annual meeting of the Board of Directors of the Middlesex Hospital was held on Nov. 2, 1939. Doctor Edgar Fauver, physician at Wesleyan University, was re-elected president. The entire Medical Board was re-elected without change. The superintendent's report showed the institution to be in a commendable financial state. It was announced that a survey by an architectural firm is under way. Its chief object is the drawing up of a plan for future expansion of the hospital's physical plant and facilities.

The main recommendations of the Staff of the Middlesex Hospital given by a representative of the Hospital Standardization Committee of the American College of Surgeons were that charts be more promptly completed and that board meetings have better attendance.

Doctor Ella Wilder of Middletown recently entertained a group of physicians and their wives at her home on South Main Street. A most enjoyable afternoon was had during which the hostess showed moving pictures of her recent trip through Yellowstone National Park and pictures taken at a physician's outing held by the Central Medical Society. The similarity be-



tween the cubs at play in Yellowstone and the physicians at play in Haddam was striking.

The program of the Nov. 13th meeting of the Central Medical Society which was held at the Middlesex Hospital consisted of the showing of a motion picture entitled "The Science and Art of Obstetrics," prepared by Doctor Joseph B. DeLee of the Lying In Hospital of Chicago. Doctor Arthur Geiger, Assistant Professor of Medicine of the Yale Medical School, spoke on "The Recent Advances in Digitalis and Allied Drugs."

Doctor Harry S. Frank of Middletown was made a Fellow of the American College of Surgeons at the annual meeting of the college held in Philadelphia. Doctor Frank is a surgeon on the staff of the Middlesex Hospital and is this year President of the Central Medical Society.

Doctor Carl C. Harvey of Middletown has returned after a two weeks' trip to the mid-west, during which time he attended the International Medical Congress in Chicago and clinics at the Mayo Clinic in Rochester.

Doctor George Armstrong, who recently retired from service on the staff of the Connecticut State Hospital in Middletown, left this month for Portsmouth, Va., where he will make his home.



### New Haven

Doctor Oliver T. Osborne, New Haven, has published a very attractive little booklet on "Gaylord Farm Sanatorium — Its Early History." The historical sketch pays fitting tribute to the many years of untiring labor of Doctor David R. Lyman.

The Journal of the Maine Medical Association, issue of November 1939, contains an article on "The Chemotherapy of Pneumonia," written by Francis G. Blake, M.D., New Haven, and read at the 87th Annual Session of the Maine Medical Association.

The open season on education in New Haven County has been a productive one so far. Waterbury continues to enlighten the brethren with first rate scholarship at the monthly meetings of the Waterbury Medical Association. In September the speaker of the evening was Dr. John Steward, Assistant Professor of Surgery, Harvard Medical School, on the subject "Pre and Post-Operative Care in the Treatment of Ob-

structive Jaundice." In October Dr. William Spain, Professor of Clinical Medicine, Post Graduate Hospital of Columbia, addressed the society on "Modern Concepts of Allergy." The "consumers" of medical care in Waterbury began their educational fare with a talk on October 19 on "The Common Cold" by Dr. Charles T. Flynn, Associate Clinical Professor of Otolaryngology at the Yale Medical School. The program projected by the Waterbury Medical Association for public education in matters of health will include a series of weekly broadcasts over Station W. A. T. R., as well as a continuation of the Public Forums. The progressive, public spirited attitude of the Waterbury Association might well stimulate some of the other organized groups of medical men in our State.

In the city of New Haven, the opening of the Yale School of Medicine with 255 registered students was preceded by the three day Clinical Congress which simply seethed with learning. Since then members of the New Haven Medical Association have had further nourishment from Dr. Richard Cateel of the Lahey Clinic, Boston, on "Carcinoma of Colon and Rectum;" Dr. Hobart Reiman, Professor of Medicine, Jefferson Medical College, Philadelphia, concerning "Observations on a Prevalent and Peculiar Type of Pneumonia" and Dr. Leo M. Davidoff, Chief Surgeon, Brooklyn Jewish Hospital, on "Hypopituitarism and Hyperpituitarism."

It was rumored that Dr. Benjamin Harris, Chairman of the Program Committee of the New Haven Medical Association, had shot his bolt with last years galaxy but the prospective parade of luminaries which he has engaged for this season belies the rumor handsomely. Current gossip favors him for permanent appointment.

The Yale Medical Society with President Harry B. Zimmerman, Associate Professor of Pathology, shooting the stars and Secretary Arthur J. Geiger, Assistant Professor of Medicine, on the lookout for submarines, started the season's voyage with a prize crew of local scholars. Dr. Walter R. Miles, Professor of Psychology, gave an illustrated lecture on the polarity potential of the human eye, Drs. Robert M. Thomas and F. L. Dessan described experimental tuberculosis in mice, Dr. Bert G. Anderson presented studies on developmental enamel defects with clinical descriptions and

classifications, and Dr. Robert M. Lewis reported on the use of synthetic preparation replacing estrin. On October 25 the Society was addressed by Dr. Arne Tiselius, Docent in Chemistry, Institute of Physical Chemistry, University of Upsala, Sweden, on "The Application of Electrophoresis Methods to Some Problems in Biochemistry and Medicine." This lecture was under the auspices of the Jane Coffin Childs Memorial Fund for Medical Research.

On November 8 Dr. Lee Farr one of Yale's most productive and promising recent graduates in medicine came back from the Rockefeller Institute to report to the Yale Medical Society on "Studies of Nitrogen Metabolism in Children with Nephrotic Syndrome."

Among regular post graduate instruction courses offered by the Yale School of Medicine to practicing physicians of the State are the Clinical Medicine-Pathology Conferences held every Monday and Friday at four-thirty p.m. in the Brady Memorial Laboratory and the Neurological Clinical Conference held every Tuesday at four-thirty p.m. in the Medical Amphitheatre, Laboratory for Medicine and Pediatrics. On November 14 the latter study unit was addressed by Dr. Percival Bailey, Professor of Neurology and Neurosurgery at the University of Illinois, on "Intracranial Sarcomatous Tumors." The Obstetrics and Gynecology conferences held one evening every month will continue throughout the year.

Grace Hospital in New Haven points with justifiable pride to their own differential income as compared with statistics for voluntary hospitals of the United States published by the U.S. Public Health Service, indicating that Grace Hospital cares for a larger percentage of ward patients than most voluntary hospitals in the country. Two new additions to the professional staff of the Grace Hospital are announced with particular satisfaction: Dr. Jachin Boaz Davis in Gynecology and Obstetrics and Dr. Thomas E. Shaffer in Pediatrics. Among recent newcomers to the field of private practice in New Haven are Dr. Samuel Spinner and Dr. William Kaufman, who were Residents in Medicine and Surgery, respectively, at Grace Hospital.

New members of the Waterbury Medical Association are: Dr. Roger B. Nelson, Dr. Robert L. Pollard and Dr. Seymour Zonn. The

New Haven County Medical Association at its One Hundred and Fifty-Sixth Semi-Annual Meeting held on October twenty-sixth at the Waterbury Country Club elected the following new members. Clarence H. Cole, New Haven, Yale 1932; Mario G. Conte, New Haven, Royal University of Naples 1935; Edward B. Lehman, New Haven, University of Tennessee 1928; Joseph A. Reynolds, Waterbury, Tufts 1936; Samuel Spinner, New Haven, Tufts 1935; Robert Tennant, New Haven, Yale 1929.

Four were accepted into membership by transfer. Paul M. De La Vergne, Meriden; Francis P. Guida, New Haven; Frank N. Lee, Milford; Thomas E. Shaffer, New Haven,

Dr. Robert A. Bonner and Dr. Richard J. Hinchey of Waterbury were reinstated to membership in the Association.

The new and old members to a total of more than a hundred enjoyed a particularly successful and congenial meeting. Luncheon and golf attracted the addicts and the leisurely, while the great mass of working members appeared for the four o'clock meeting at which Dr. Cole B. Gibson presided. Dr. Reginald Fitz, Consulting Physician to Peter Bent Brigham Hospital, Lecturer on History of Medicine, Harvard Medical School, discussed "The Present Status of the Hypertensive Problem." After dinner Professor Harry R. Rudin of the History Department, Yale University, spoke eloquently about "The European Situation." The informal gathering for further refreshments and conversation later in the evening concluded another meeting of the New Haven County Association notable for interest and good spirits.

Officers of the Association for 1939-1940 are: President, Cole B. Gibson, Meriden; Vice-President, J. Harold Root, Waterbury; Clerk, Ralph E. McDonnell, New Haven; Councillor, Thomas P. Murdock, Meriden; Executive Committee, The President and the Vice-President, The Clerk, Michael Lawlor, Joseph I. Linde; Censors, Charles Larkin, Raymond Quinlan, Louis Nahum; Credential Committee, Frederick Roberts, William Hall, Max Ruby; County Delegates, Fairfield — Maxwell Lear, Litchfield — Sherburne Campbell, Middlesex — Abe S. Brown, Windham — Ralph Nichols, Tolland — Edward W. Foster, Hartford — J. Harold Root, New London — Frederick W. Roberts.



## Tolland

The regular semi-annual meeting of the Tolland County Medical Association was called to order on Oct. 17 by its President, Doctor Alfred Schiavetti, after dinner at the Olde Homestead Inn, Somers. The small delegation of members was outnumbered by its guests. Doctor Joseph I. Linde, President of The Connecticut State Medical Society, gave a brief talk, stressing the importance of pressing the battle against syphilis. Doctor James D. Gold spoke briefly and again explained the necessity for a full time Secretary for the State Society. Other guests were Doctor Maudie M. Burns and Doctor Margaret Mac Lean, from the State Department of Child Welfare, and Doctor F. Arthur Emmett of Hartford. The speaker of the evening was Doctor William P. Daly of Hartford, who spoke on the Complications of Pregnancy and cautioned greater use of expectant and conservative treatment in labor.



## EYE AND EAR SPECIALISTS ELECT OFFICERS AT ANNUAL SESSION

Dr. Frank R. Spencer, Boulder, Colorado, was chosen president-elect of the American Academy of Ophthalmology and Otolaryngology at the annual session in Chicago, Wednesday night, October 11. He will succeed Dr. Frank E. Brawley, Chicago, when the latter becomes president of the Academy January 1, Dr. Spencer will become president Jan. 1, 1941.

Dr. Spencer, 60 years old, is a native of Iowa and a graduate of the University of Michigan Medical School, 1902. He has been a member of the faculty of the University of Colorado School of Medicine since 1905 and is now professor and head of the department of ear, nose and throat diseases. He has been president of the Colorado State Medical Society, the Colorado Otolaryngological Society and of the Colorado State Board of Medical Examiners.

In addition he has been active in various national organizations, having served as an officer of the American Laryngological Association, the American Laryngological, Rhinological and Otological Society and as chairman of the section on laryngology, otology and rhinology of the American Medical Association. He is also a member of the American Otological Society and a charter member of the American Board of Otolaryngology.

The Academy also decided to act as sponsor for a proposed Pan American Congress of ophthalmology and otolaryngology. South American physicians attending the meeting in Chicago will arrange for the attendance of delegates from their respective countries to such a congress to be held in connection with the next meeting of the Academy, it was said.

It is understood that invitations to each of the countries concerned will have the sanction of the Department of State and will be forwarded through diplomatic channels.

The Academy continued the following appropriations for research; Olof Larsell, Ph. D., University of Oregon Medical School, Portland, \$400 for research on development of the internal ear; Dr. M. H. Lurie, Harvard Medical School, Boston, \$400 for research on the balancing apparatus of the ear, and Army Medical Museum, Washington, D.C., \$1500 for maintaining collections of pathological specimens in diseases of the eye, ear, nose and throat.

Appropriation was also made for a new venture in graduate medical education. The Academy plans to establish under its supervision reading courses for young physicians serving as residents in hospitals who are preparing for specialization in diseases of the eye, ear, nose and throat. The council set aside \$1,500 for this purpose.

Another new grant went to Dr. Frank R. Spencer, Boulder, Colorado, who received \$400 for research on the action of drugs on tubercle bacilli in the nose and throat. The committee on physiologic optics received \$50 and the committee on orthoptics \$200.



## PROPER WEIGHT

With the amount of evidence which has been produced to show the dangers of excessive variations from normal weight, and in particular overweight, it is unfortunate that the public is not fully aware of the desirability of keeping within normal limits.

It should be a challenge to the medical profession to educate the laymen to the fact that unfavorable weight is not only a definite impairment of health but also an important factor towards increased mortality.

*Proc. Life Ext. Exam. July-Aug. 1939*

## SPECIAL NOTICES

### NEW ENGLAND OBSTETRICAL AND GYNECOLOGICAL SOCIETY

At a meeting of the Executive Committee of the New England Obstetrical and Gynecological Society it was voted to hold the annual meeting in Boston, Massachusetts, on Wednesday, December 6. The Carney Hospital, the Massachusetts General Hospital and the Lahey Clinic are to be requested to hold morning clinics and an afternoon clinic is to be held at the Boston City Hospital.



### INTERNATIONAL COLLEGE OF SURGEONS

The Officers of the United States Chapter of the International College of Surgeons cordially invite all physicians and surgeons in good standing to their Fourth Assembly, to be held in Venice, Florida, February 11-14, 1940. There is no registration fee.

For general information please address Dr. Fred H. Albee, Chairman, 57 West 57th Street, New York City. For information about the presentation of scientific papers or exhibits, query Dr. Charles H. Arnold, Secretary of the Scientific Assembly, Terminal Building, Lincoln, Nebraska.



### AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The written examination and review of case histories (Part I) for Group B candidates will be held in the various cities of the United States and Canada on Saturday, January 6, 1940, at 2:00 P.M. Formal notice of the place of examination will be sent each candidate several weeks in advance of the examination date. No candidate will be admitted to examination whose examination fee has not been paid at the Secretary's Office. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held in June 1940. Receipt of Group B applications for the current examination (January 6, 1940) closed October 4, 1939.

Candidates for *reexamination* in Part I (written paper and submission of case histories) must request such reexamination by writing the Secretary's Office not later than November 15, 1939. Candidates who are required to take reexaminations must do so before the expiration of three years from the date of their original examination.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting in Atlantic City, N.J., on June 8, 9, 10, and 11, 1940, immediately prior to the annual meeting of the American Medical Association in New York City.

Application for admission to Group A, Part II examinations must be on file in the Secretary's Office not later than March 15, 1940.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I and Part II examinations.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

### THE AMERICAN BOARD OF OPHTHALMOLOGY

WRITTEN EXAMINATION, March 2nd, 1940, in various cities throughout the country.

THIS WILL BE THE ONLY WRITTEN EXAMINATION IN 1940.

All applications for this examination must be received before January 1st, 1940. All applicants must pass satisfactory written examination before being admitted to oral examination.

ORAL EXAMINATION: New York City, June 8th and 10th. Fall examination to be announced later.

CASE REPORT: Candidates planning to take June examination must file case reports before March 1st.

For application blanks write AT ONCE to

Dr. John Green  
6830 Waterman Ave.,  
St. Louis, Mo.



### RATIONAL THERAPY

(Continued from Page 657)

cription, they keep a record of the deal and can readily guarantee the contents of a prescribed and compounded drug better than they can back up the contents of a ready made combination of uncertain parentage. They can supply the medications at a lower cost to the patient and a better profit to themselves.

Of what then does rational medical therapy consist? The use of drugs in proper dosages, strength, and duration of treatment, drugs which we as physicians are best qualified to judge, not by a smooth or euphonic name, but by a pharmacologic action. Let us, if we need to prescribe, give thought and time to the contrivance of a medication and not the first clever advertisement that comes to mind.



### SULFAPYRADINE IN TREATMENT OF PNEUMONIA

(Continued from Page 671)

7. Marshall, E. K., Jr., and Long, P. H. J.A.M.A. 112: 1671, 1939.

8. Long, P. H. J.A.M.A. 112: 538, 1939.

9. Johnston, F. D. Lancet 2: 1200, 1938; Coxon, R. V., and Forbes, J. R. Lancet 2, 1412, 1938.

10. Hageman, P. O., and Blake, F. G. J.A.M.A., 109: 642, 1937.

The sulfapyridine used was supplied through the courtesy of Merck & Co.



## • OBITUARIES •

### HENRY SMITH TURRILL, M.D. 1885—1938

Doctor Henry Smith Turrill, for 23 years a practicing physician at Kent, died at his home in that village on June 7, 1938 of congestive heart failure. He was born in Wellsville, near New Milford, August 1, 1885, the son of Frederick Jay and Julia Frances Smith Turrill. Educated in the town schools of New Milford, he took his college course at Yale University, graduating with the degree of Ph. B. in the class of 1906, and he received his M.D. in the Yale Medical School in 1910. He was an interne in Jamaica hospital in Jamaica, Long Island, 1910-11 and began practicing at Canaan, Connecticut, in 1912, removing to Kent in 1915. Here he was in continuous practice for 23 years.

Doctor Turrill was a member of the American Medical Association and of the Litchfield County Medical Association, also Secretary of the Litchfield County Public Health Association and Health Officer of Kent for a long time. When the Kent School was founded in 1906 Dr. Turrill was made school physician and his services were invaluable also as athletic coach, for he had been a member of the football squad while in college. He practically grew up with the school where he was known as Uncle Henry to all of the earlier graduates. He was also physician to the South Kent School from the time it was started. His one hobby was the Boy Scout movement and the troop at Kent under his fostering care was one of the best in the county. He was one of the attending staff at the Sharon Hospital, very faithful in attendance at the staff meetings, always having something to add to the matter under discussion. He was popular with members of his profession. A hard working, faithful, devoted family physician of the best type, his early death at the age of 53 is a severe loss to his town and to his friends. Dr. Turrill was married February 6, 1912 to Edith Josephine Ferriss of New Milford who survives him with two sons, Roger Frederick and John Ferriss.

Jerome S. Chaffee, M.D.

## • Quarto Notes •

### NITROUS OXIDE-OXYGEN ANESTHESIA. McKESSON-CLEMENT VIEWPOINT AND TECHNIQUE

by

F. W. Clement, M.D.

274 pages

Philadelphia

70 engravings

Lea and Febiger

This volume is dedicated as a memorial tribute to the life, work and achievements of E. I. McKesson, M.D., who was the foremost exponent of the usefulness of nitrous oxide and who also was the most skillful in its administration. This book is written by a man who was McKesson's friend, partner and co-worker and he is now carrying on the work of demonstrating the usefulness of this agent with the same skill.

In this compact text the theory of nitrous oxide anesthesia is lucidly explained and the signs and symptoms are outlined in orderly fashion. Chapter IV deals with proper evaluation of the patient's physical state and the influences of proper preliminary medication on metabolic functions. The recognition and treatment of shock is thoroughly discussed in chapter V. In chapter VII such interesting topics as technique of induction, muscular relaxation, the depression test and oxygen apnea are covered adequately and well. Chapter IX is reserved for the important topic of anoxemia and cyanosis in relation to it. The author is confident that there is no real basis for the claim that destruction of highly specialized cells of the cerebral cortex results from direct action of nitrous oxide upon these tissues. The real explanation is that cortical damage results from a severe anoxemia produced by a deprivation of essential oxygen, such as may result from prolonged deep narcosis ineptly controlled.

The role of carbon dioxide in respiration is discussed in relation to blood pressure, blood flow, apnea, dissociation effect and alkali reserve. In the next chapter discussion of rebreathing and stabilization of respiration naturally follows. Again the summary is excellent. In chapter XIII primary and secondary saturation is discussed and the management of patients subjected to secondary saturation is given adequate consideration.

The advantages and disadvantages of nitrous oxide are outlined and comparison of this gas with other anesthetic agents is made.

Chapters XVIII, XIX and XX deal with special techniques involving the use of positive pressure, endotracheal catheters and carbon dioxide absorption. Chapter XXI contains many useful suggestions for the management of patients undergoing particular operative procedures. A section is devoted to obstetrical analgesia and anesthesia. Part 5, or chapter XXII, is devoted exclusively to the consideration of nitrous oxide anesthesia for

dental surgery. Part 6 is a reprint of a paper on "Some Physical Factors in the Administration of Gaseous Anesthetics" by Dr. E. I. McKesson and presented by him before the Fifth Annual Congress of Anesthetists held in Nottingham, England, in 1925.

This book is concisely written by a man who not only knows his subject well from the theoretical side but also has the rare faculty of being able to demonstrate and to teach others practical applications of these theories in the operating room. He has now demonstrated his ability to prepare expertly a treatise which will be of interest and real value to obstetricians, dentists and anesthetists.

R. M. Tovell



## SURGICAL APPLIED ANATOMY

by

Sir Frederick Treves, Bart.

10th Edition, revised by

Lambert Rogers, F.R.C.S.

748 pages	192 figures, 66 in color	\$4.50
Philadelphia	Lea & Febiger	1939

This pocket-sized manual of anatomy is again brought up to date. One might wonder what changes in anatomy have occurred since the 9th edition appeared 5 years ago, until he noted that this textbook of anatomy points out the anatomical details of most practical value, particularly as applied to surgery. Obsolete operative procedures have been omitted from the discussion and modern concepts of anatomy in relation to pathological processes are stressed, — as for example, in the eye the changes occurring in glaucoma are related to the underlying anatomical structures, and likewise, in the hand, Kanaval's work on the palmar spaces is outlined in connection with the spread of infection.

Particular attention has been paid to the anatomical details so necessary to the practice of orthopedics; to the clinical manifestations of injuries to nerves; and to the embryological background of frequently encountered congenital abnormalities.

One omission might be mentioned. There is no reference to the surface markings for the individual lobes of the lungs which is important in localizing pneumonia, etc., from physical signs.

The usefulness of this little reference book is best indicated by quoting from the preface to the 1st edition of 1883:

"The book is intended mainly for the use of students preparing for their final examination in surgery. I hope, however, that it will be of use also to practitioners whose memory of their dissecting-room work is growing a little grey, and who would wish to recall such anatomical matters as have the most direct bearing upon the details of practice. Moreover, it is possible that junior students may find some interest in the volume, and may have their studies rendered more intelligent by learning how anatomy is concerned in actual dealings with disease."

Today, 56 years later, no further comment is necessary.

W. F. Smith

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| 2. Fermentation of dextrose | 4. Agglutination test        |
| 5. Alkali solubility test   |                              |

\*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

Silver Picrate is a crystalline compound of silver in definite chemical combination with picric acid. Dosage form for use in Anterior Urethritis: Wyeth's Silver Picrate Crystals used in an aqueous solution of 0.5 percent.

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## NUTRITION AND DIET IN HEALTH AND DISEASE

by

James S. McLester, M.D.

Professor of Medicine, University of Alabama.

838 pages	3rd edition	\$8.00
Philadelphia	W. B. Saunders Co.	1939

Doctor McLester needs no introduction to practitioners of medicine. He is conceded a position of authority on any subject pertaining to the diet of the patient. The two previous editions of this work have been widely accepted as invaluable aids in improved feeding programs of both the well and the sick. The present edition appears with much that is new between its covers, due to the rapid advances during the past 25 years in the knowledge of vitamins and the deficiency diseases, of insulin therapy and of the large and seemingly limitless field of allergy.

Much of the text is new, all of it is rewritten and recipes and diets are improved to conform to modern conceptions of illness and proper therapy. A striking increase is noted in the amount of material found in the chapter on vitamins, more than five times that appearing in the previous edition. Much more is known about body minerals, about deficiency diseases, about diseases of the kidney and the urinary tract, now than formerly. The treatment of gastric ulcer has undergone a marked change. Dietary treatment of diseases of the heart and arteries is brought up to date, as well as that of diseases of the blood, of the joints and of the nervous system.

One of the most valuable chapters deals with feeding of the surgical patient. To one who was familiar with the purging and starvation earlier in this century this chapter will offer a striking contrast.

As a reference for internist, surgeon, pediatricist and neurologist Doctor McLester's book should prove exceedingly valuable.

The material is very well classified, making it readily accessible; the diets and charts are numerous and extremely helpful.



## 1939 YEAR BOOK OF RADIOLOGY

by

Charles A. Waters, M.D.

and

Ira I. Kaplan, M.D.

528 pages	\$4.50
Chicago, Ill.	The Year Book Publishers, Inc. 1939

This book, in which 397 articles of the year have been abstracted, is divided almost equally between diagnosis and therapeutics. Approximately one half the articles have been selected from 51 scientific publications in 12 foreign countries, the remainder from 49 scientific publications in this country. All the latest advances in radiological diagnosis and treatment are included in the book. There are over 500 good illustrations, each of which is accompanied by an explanatory note. Timely editorial comments on many of the articles add to the value of the book.

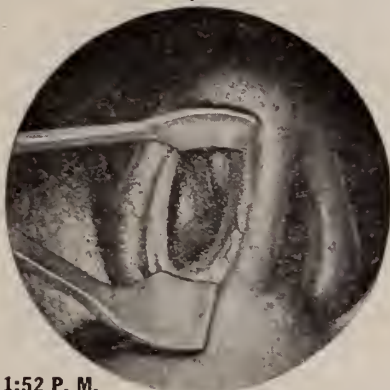
There are comprehensive subject and author indexes. The large number of publications from which the articles have been selected, together with these indexes, makes this a valuable reference book, not only for the radiologist, but for other specialists and general practitioners as well.

W. C. Hall

# Effective Lasting Shrinkage

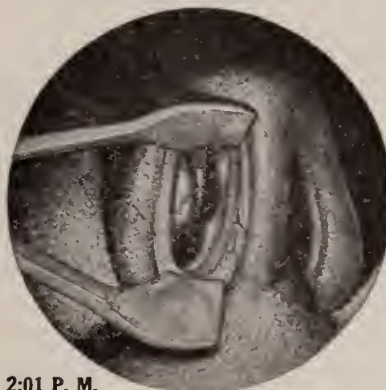
*Case History:* F. O'B. Age 23, male, white. Worker in chromic acid plant. Complained chiefly of earache and head stoppage. Observed at Nose and Throat Clinic of a Philadelphia hospital.

## EFFECTIVE IN MINUTES



1:52 P. M.

Swollen turbinates and septum. Two inhalations from 'Benzedrine Inhaler.'



2:01 P. M.

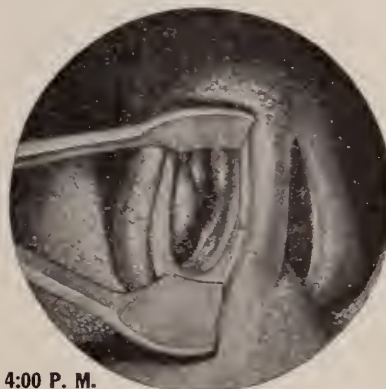
Maximum shrinkage. Inferior and middle turbinates and septum decongested.

## LASTING FOR HOURS



3:15 P. M.

Inferior turbinate and septum still shrunk. Middle turbinate exposed.



4:00 P. M.

Both turbinates still contracted. Very slight return of turgescence.

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## STATUS OF JEWISH PHYSICIANS

In discussing the question of overcrowding, the status of the proportion of Jews in the medical profession arises. This subject is at present in the limelight in view of the persecution of the Jews in Germany and their immigration into this country.

According to Bevan, fourteen years ago 10 per cent of the students in our medical schools were Jews. In 1935 the percentage had increased to 20 per cent, and Rabbi Lazaran has found that in 1933, 32 per cent of the applicants for admission to the medical school were Jews. With 42 per cent of all the Jews in the United States located in New York City, the problem in New York State is particularly difficult. The medical schools in New York City can obviously not accommodate all the Jewish students, and many apply elsewhere. That there has been obvious discrimination against Jewish applicants to medical schools in general is indicated by the fact that whereas only 3.5 per cent of the general population of the country is Jewish, Rypins found 17 per cent of medical students belonging to this race.

*Minn. Med., Sept. 1939*



## GREATER USE OF SURGERY IN TUBERCULOSIS RESULTS IN CHANGES IN THE HOSPITAL

Probably the most significant and far-reaching change which has come about in the tuberculosis hospital field is the trend toward surgical treatment of the disease. This has involved changes in design and equipment of the hospital, in the organization of the staff, in provision for nursing of surgical cases and development of closer relations with general hospitals. Wherever the tuberculosis hospital is not prepared to meet the demand for better operating rooms, laboratories and x-ray equipment the facilities of the general hospital must be utilized. *Hospital Management, Sept., 1939.*

## A Method of Administering SULFAPYRIDINE to Inhibit Nausea and Vomiting

The use of Kalak Water as a vehicle for the administration of sulfapyridine appears to inhibit and, in some cases, entirely eliminate nausea and vomiting when the following procedure is adhered to:

1. Give patient 6 oz. of cooled Kalak to sip slowly.
2. Add the sulfapyridine to ice-cold Kalak. For each 0.5 gm. tablet, use 2 oz. of Kalak. When effervescence has ceased the drug is in suspension and ready for use.
3. Give the patient a few ounces of cooled Kalak to aid in the absorption of the drug.

It has been noted that this employment of Kalak tends to inhibit the formation of calculi, a result which occasionally occurs upon protracted sulfapyridine therapy.

Kalak is palatable, carbonated, physiologically balanced in terms of the bicarbonates of calcium, sodium and potassium. It is not a laxative.

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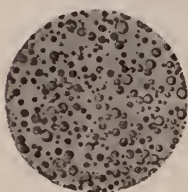


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